Mount Stuart Hospital

Quality Report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Mount Stuart Hospital is an independent hospital and part of the Ramsay Hospital Group. At the time of our inspection, it provided care and treatment to NHS patients and privately funded patients; including self-funded and medically insured.

The hospital provided surgery, and outpatient and diagnostic services. There were no services provided to persons under the age of 18. Day case and inpatient surgery specialties included general surgery, major and minor orthopaedic surgery, ophthalmology, ear nose and throat surgery, gynaecology, urology, dermatology, endoscopy and cosmetic surgery. There were 26 inpatient beds and 12 ambulatory care spaces. There were three main operating theatres, one day case theatre, and a recovery area. There was a physiotherapy service for patients on the ward.

The outpatient department provided a stand-alone service for patients and a service before and after surgery. Outpatient specialities included orthopaedics, general surgery, gynaecology and obstetrics, cosmetic surgery, ear nose and throat, urology, oral and maxilla, ophthalmology, gastroenterology, dermatology, and facial surgery. Diagnostic imaging included plain x-ray, ultrasound, and fluoroscopy. magnetic resonance imagining (MRI) and computed tomography (CT) were provided from a mobile unit by Ramsay UK Diagnostics and were not inspected as part of this visit. Non-surgical cosmetic treatments delivered by the cosmetic suite were not inspected as part of this visit. There was a private physiotherapy service for outpatients.

All treatments were consultant led. All consultants were employed under practicing privileges. The senior leadership team included the general manager, matron, operations manager and decontamination lead, regional finance manager, regional business development manager, personal assistant and human resources lead, and business administration manager. Clinical heads of department reported directly to the matron. Since our last inspection a full time matron had been employed.

We carried out a comprehensive announced inspection of Mount Stuart Hospital on 6 and 7 September 2016, and an unannounced inspection on 15 September 2016. We inspected and reported on two core services: surgery, and, outpatients and diagnostic imaging.

We rated Mount Stuart Hospital as requires improvement. We rated both surgical services and outpatient and diagnostic imaging services as good for caring and responsive. We rated both services as requires improvement for safe and for surgical services inadequate for well led. We rated surgery as requires improvement for effective, but we did not rate the effectiveness of the outpatient and diagnostic imaging service due to insufficient data being available to rate these departments' effectiveness nationally.

Our key findings were as follows:

Are services safe?

We rated safety as requires improvement:

- The management of incidents did not consistently follow the hospital policy. The management of duty of candour was well understood by staff but its implementation not consistently practised after an incident had occurred.
- There was a lack of up to date service level agreements with acute NHS hospitals for the transfer of patients requiring critical care.
- Not enough staff were directly employed by the hospital to staff the theatres and so agency and bank staff were being used. At our announced inspection 44% of theatre staff were agency and bank staff. Theatre staff were unaware of which skills agency staff had, but action had been taken to address this by the time of our unannounced inspection.

Summary of findings

- Infection prevention and control practice was not in line with best practice. Hazardous waste was not managed safely and the flooring in consulting rooms and patient rooms was non-compliant with guidelines for infection control, not always cleaned, and had not been risk assessed.
- Clinical audit arrangements were inconsistent with no consistent departmental actions or timescales. Some aspects of clinical audits scored consistently low with no improvement in scores being demonstrated.
- Some areas of the theatre and ward environment required review including the emergency call system in recovery. The management of damaged equipment made its replacement prolonged.
- There was not clear resuscitation procedures in response to a medical emergency. Resuscitation scenarios had not been practiced in the hospital since July 2014. Fire evacuation drills had not been practiced in over a year and had not taken place since the opening of new theatres and ambulatory care.

However,

- There was a culture of reporting and learning from incidents throughout the hospital.
- The matron was safeguarding lead for the hospital with support during working hours from the Ramsay Hospital Group safeguarding lead. Safeguarding practices were clear, and staff were aware of the actions needed if they had concerns. Staff told us about examples of appropriate safeguarding referrals.
- There was good handover of patients between staff and staff contacted and discussed the patient's condition with consultants when required.

Are services effective?

We rated effective as requires improvement.

- Information about outcomes of patient care and treatment was not routinely collected and monitored for all patients.
- Assessment of nutrition and hydration were not consistently completed and so risks to patients were not always identified.
- Consent for cosmetic surgery was not in line with company or national best practice.
- Audits were not regularly completed. Actions seen as a result of audits were not followed up to ensure they had been completed.
- Staff appraisals were not always completed which meant staff were not provided with an opportunity to review their skills, performance and development.

However,

- Treatment was in line with best practice guidelines and staff applied this to their practice.
- Practising privileges for consultants were up to date and monitored regularly and any changes responded to.
- Multidisciplinary team working was evident between staff of different roles and from different departments to deliver effective patient care.

Are services caring?

We rated caring as good.

- Staff were professional, kind and attentive with a focus on individualised patient care.

Summary of findings

- Patients were kept informed at all times and included in their plan of care, this included discharge arrangements which considered the patients home circumstances. Patient's privacy and confidentiality was respected at all times.
- Feedback from patients was positive about staff and the service they received at the hospital. Patient questionnaires indicated high levels of patients would recommend the service and a high number of patient comments were positive.
- Staff recognised how they could provide emotional support for patients including identifying anxieties and responding to put the patient at ease.
- Patients were individually supported when intimate examinations were taking place with a chaperone. The availability of a chaperone for any patient was well advertised in patient facing areas.

Are services responsive?

We rated responsiveness as good.

- Services were planned to meet patients' needs. The hospital was meeting referral to treatment time guidance, patients had the flexibility to arrange a suitable appointment time, and the flow of patients from pre-admission through to discharge was well organised.
- The individual needs of the patients were identified and considered when delivering the patient pathway. Staff had time to explain to patients how their care would be delivered and so patients were well informed about their treatment.
- In theatres, staff were able to respond to the needs of patients out of normal working hours through the use of an on call team. Extra staffing was requested dependant on the workload.
- Complaints were managed effectively and investigations were inclusive of all individuals associated with the complaint. Clinical complaints were overseen by the matron. Learning from complaints and actions were shared with the appropriate individuals.

However,

- There was no clear process for releasing staff from their normal duties if they had been called in or worked longer shifts.

Are services well led?

We rated well-led as inadequate:

- The vision and strategy for the hospital was defined at a corporate level but not clearly defined at a hospital level. Not all services had a strategy for their department and there was not a current clinical strategy.
- There was not an effective governance framework or strategy to support delivery of good quality care.
- Governance processes were not in place and clearly defined to monitor services. Audits were not completed regularity, actions not always followed up, and there was a lack of audits at a departmental level to identify specific issues.
- There was not a complete and accurate systematic programme of clinical and internal audit to monitor quality systems and identify action. Audits were not regularly completed and the results available were not regularly reviewed to ensure they were adequate. Actions seen as a result of audits were not robust or followed up to ensure they had been completed.
- Since our previous inspection in March 2016, the planned changes in governance, risk management and quality by the provider had not been actioned at a suitable pace to ensure patient safety.

Summary of findings

- There was no effective system for identifying, capturing and managing issues and risks at a local department level. Staff were unaware of hospital or departmental risks. Staff were unsure of how to escalate a risk to the risk register and risks were not managed or reviewed at a departmental level.
- Clear departmental management was not evident in all departments to ensure safe practice. Staff meetings did not always take place and what was discussed was not always written down for staff to review.

However,

- The corporate values, 'The Ramsay Way,' were understood and demonstrated by staff.
- Staff were positive about their departmental managers and the hospital management team. Staff felt management were visible and approachable.
- Since the inspection an appropriate response has been received following the issue of a requirement notice for good governance.

There were areas where the provider needs to make improvements.

Importantly, the provider must:

- There were not clear governance processes in place to monitor the service provided. Audits were not regularly completed. Actions seen as a result of audits were not followed up to ensure they had been completed.
- The provider must have in place a complete and accurate systematic programme of clinical and internal audit which can be used to monitor quality systems to identify what actions should be taken. Comprehensive audits should be completed specific to departments to allow performance and compliance to be monitored at departmental level.
- There were no local risk registers in place and no department ownership of how risks were identified and managed.
- The management of duty of candour was not well understood and its implementation not consistently practised.
- Cosmetic surgery services did not follow the company policy. Psychological reviews had not been considered, recorded or undertaken to ensure that appropriate consideration had been given around body image and patient expectations. There was no record of the cooling off period of time between initial consultation and the date for surgery. Consent for cosmetic services was not in line with company and national guidelines.
- The provider must ensure the arrangements to respond to a medical emergency in the outpatient and diagnostic imaging departments are clear amongst staff, practiced regularly and be assured the resuscitation equipment is readily available. The provider should review the single use resuscitation bag present in physiotherapy department.
- Resuscitation scenarios as a practice exercise had not taken place since July 2014. A resuscitation team had recently been implemented and part of their role was to plan and produce these scenarios. This had not yet taken place and training for this role was not planned until November 2016
- The provider must have an action in place to remove all non-compliant sinks.
- The provider must review their compliance with the Royal College of Surgeons professional standards for cosmetic practice, ensuring consent is obtained in a two-stage process with cooling off period of at least two weeks between stages to allow patients to reflect on their decision.

In addition the provider should:

- Staff should ensure that all medicines are stored securely and at the correct temperature. Staff should know how to reset thermometers and what action to take when readings are recorded outside of the recommended range.

Summary of findings

- Medicines, including emergency medicines should be stored securely.
- A fire drill to inform staff of hospital practice should take place. No fire drill had been completed in the previous 12 months, in this time the new theatre and ambulatory carehad been opened.
- Sufficient plans should be in place for cover the following day shift for the out of hours on call theatre team, should they be called in.
- Daily testing of the critical care/resus team bleep should take place to ensure the system is effective.
- Timescales should be recorded of governance of areas reviewed by the Clinical Governance Committee which required an action plan.
- Theatre management was not evident at all levels to ensure safe practice. Leadership should be clear in the scope for their service delivery.
- Assessment of nutrition and hydration should be consistently completed to ensure effective identification of risks to patients.
- Not all staff had received an annual appraisal of their skills and performance. This should be completed for all staff.
- Service level agreements with local trusts for the transfer of patients in an emergency should be updated and the agreement signed.
- Safety review for non NHS patients should be undertaken to ensure there is an overview of patient safety.
- The provider should ensure there is a clearly documented exclusion criteria to be followed for both NHS and private patients.
- The provider should consider how patient outcomes can be monitored and measured in the outpatient and physiotherapy departments.
- The provider should review how cosmetic patients are assessed for the requirement of a psychological review.
- The provider should ensure processes are in place to assure themselves the consultants are abiding by the clinical photography policy and the photos being taken of patients are managed confidentially, kept secure and deleted on a timely basis.
- Some areas of theatre and ward environment should be reviewed to ensure their safety, these included the completion of the theatre development and an emergency call system in recovery. The management and process of damaged equipment made its replacement prolonged and should be improved.
- The provider should ensure the use of carpets in the outpatient department has been risk assessed and included on the risk register.
- The provider should consider implementing departmental risk registers to allow departmental risks to be recorded and managed effectively.
- Patient's theatre gowns were thin material and small. This should be reviewed to ensure patient dignity and purpose.
- The outpatient department should review the risk of cross infection of staff eating and drinking in a clinical area.
- The safe use of the three-part decontamination system for nasopharyngeal endoscopes should be reviewed and goggles should be made available for personal protective equipment.
- The provider should review the layout of the outpatient department to access the sluice and the risks of dirty items being transported through clean areas.

Summary of findings

- The outpatient department should ensure they have appropriate stock rotation in consulting and treatment rooms.

Professor Sir Mike Richards Chief Inspector of Hospitals

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	• The management of incidents did not consistently follow the hospital policy; more serious incidents were not always investigated properly. Duty of candour was understood however, its implementation was not consistently practised. • Mandatory training was not fully compliant. • Medicine systems were mostly safe, however the storage of fluid and temperature monitoring required action to ensure safety. • The management of infection control showed that not all staff were fully trained, monitoring was limited and cleaning audits were not fully completed. • Some areas of theatre and ward environment were in need of review, these included the completion of the theatre development programme underway and an emergency call system in recovery. The management and process of replacing damaged equipment was prolonged. • Agreements with local trusts for the transfer of patients in an emergency were out of date and required update and agreement. • The WHO checklists were not consistently audited to provide assurance they were correctly and fully completed. When shortfalls were seen, actions were not followed up to ensure improvements were made. • Anaesthetic audits did not prompt remedial action to be recorded. The action plans undertaken as a result of the audit did not prompt change of practice. • Records maintained of the deteriorating patients early warning scores (EWS) had been audited and shortfalls found. No follow up audit had taken place to ensure patient safety. Training for staff had been put in place but had not been evident in changing staff practice.

Summary of findings

- Auditing of VTE did not evidence change in practice and showed deterioration in completion of a section relating to the post surgery review of prophylaxis by the surgeon. There were not sufficient actions or reviews taking place to ensure patient safety.
- Cosmetic surgery services did not follow the company policy psychological reviews had not been considered, recorded or undertaken to ensure that appropriate consideration had been given around body image and patient expectations.
- Resuscitation scenarios as a practice exercise had not taken place since July 2014. A resuscitation team had recently been implemented and part of their role was to plan and produce these scenarios. This had not yet taken place and training for this role was not planned until November 2016.
- No fire drill had been completed in the previous 12 months, this included opening of new theatre and ambulatory care.
- There were not enough whole time equivalent staff employed by Ramsay Health Care to staff the three theatres and so at this inspection 44% of agency and bank staff were being used.
- The outcomes for patients care and treatment is not always monitored. Clinical audits were not fully completed to ensure an effective service was being provided. No audits of cosmetic surgery were taking place.
- Staff did not always have the complete information they need to provide care and treatment. Assessment of nutrition and hydration were not always completed using the malnutrition universal screening tool (MUST) and so risks to patients could not always be identified. Audits of nutrition and hydration were not available to assess service provision.
- There were gaps in support arrangements for staff. Not all nursing and ward staff had received an annual appraisal of their skills and performance.

Summary of findings

- Consent for cosmetic services was not always obtained or recorded in line with in line with company and national guidelines. Timescales for consent were not followed to ensure all patients had a two week cooling off period between initial consent to surgery and the consent on the day of surgery.
- Patient theatre gowns were made of thin material and small in size.
- Information for patients on how to complain or comment was not available in patient rooms but was available on request from the nurses station.
- The governance arrangements were not followed to ensure a complete overview of the service being provided. Governance systems did not drive a change in quality of service. The information used to monitor performance was not used to change and improve practice. Governance of areas reviewed by the Clinical Governance Committee which required an action plan did not all have timescales for action to be completed.
- There was not a complete and accurate systematic programme of clinical and internal audit to monitor quality systems and identify action. Audits were not regularly completed and the results available were not regularly reviewed to ensure they were adequate. Actions seen as a result of audits were not robust or followed up to ensure they had been completed.
- Since our previous inspection in March 2016, the planned changes in governance, risk management and quality by the provider had not been actioned at a suitable pace to ensure patient safety.
- There is a lack of clarity about leadership and decision making, quality and safety were not the top priority for leadership. Theatre management and leadership was not evident at all levels to ensure safe practice.
- There was no effective system for identifying, capturing and managing issues at a local department level. There were no local risk registers in place and no department

Summary of findings

ownership of how risks were identified and managed. Issues that impact on clinical care were not identified and adequate action to manage them was not always taken. Risks were not used to prompt actions. At a departmental level risks were not identified and addressed. The risks previously identified at the CQC March 2016 inspection were not included in detail the current risk register.

- Next day cover for the out of hours on call theatre team, should they be called in, was not in place.
- There were low levels of staff satisfaction with leadership. The Ramsay staff survey highlighted low staff scores around local and corporate leadership which indicated shortfalls in management.
- However:
- The hospital promoted a culture of reporting and learning from incidents.
- Safeguarding practices were clear and the majority of staff we spoke with were aware of the actions needed if they had concerns.
- The sterile equipment for theatre was well managed, effective and audited to ensure a safe service was provided.
- Treatment was provided in line with national guidance and staff were aware of the relevant National Institute for Health and Care Excellence (NICE) guidance.
- Some national audit information about patients care and treatment and their outcomes was collected and monitored.
- Patients received treatment which considered their levels of pain
- With the exception of cosmetic surgery records, records showed consent to care and treatment was obtained in line with legislation and guidance.
- Feedback from patients was positive about the way staff treated them. Patients confirmed staff were professional, kind and attentive. Staff were seen to be kind and caring and their focus was on individualised patient care.
- Patients were encouraged to be involved in decisions about their care. Patients were kept

Summary of findings

informed at all times about their plan of care. The handover of information between staff included the patient and was inclusive of their views. This included both the admission and discharge process. Patient's privacy and confidentiality was respected at all times.

- Patients anxieties were assessed and monitored to ensure patient was as comfortable as possible.
- Services were planned to meet patients' needs. The flow of admissions and discharges through the hospital were well organised. Patients were kept informed of any disruption to their care and treatment.
- The needs of different patients were considered in the planning and delivering of the service. Further work was needed to develop dementia care as part of the service.
- Discharge arrangements considered the patients home circumstances and care arrangements. This included patients being allowed to stay longer to ensure an effective discharge.
- Complaints were all responded to in a timely manner by the hospital manager and learning from complaints was demonstrated
- Waiting times were well under the guidance threshold of 18 weeks.
- The corporate values were understood by staff and included in induction and staff were aware of a local strategy in theatres.
- Since the inspection an appropriate response has been received following the issue of a requirement notice for good governance.

Outpatients and diagnostic imaging

Requires improvement

- A high number of infection control risk areas throughout the outpatient department.
- In the absence of hazardous waste bins in consulting rooms, hazardous waste was not managed safely and had been placed within the household waste stream.
- There were not clear resuscitation procedures in response to a medical emergency. Staff

Summary of findings

confusion was apparent with locating the resuscitation grab bag or ward resuscitation trolley and resuscitation scenarios were not practiced in each department.

- Medicines were not always stored within the manufacturers recommended temperature range.
- There was no eligibility criteria for private patients, therefore consultants did not have clear guidelines for selection of patients which could be safely treated at the hospital.
- A fire drill had not been completed in over one year and in this time changes had been made to the building.
- The cosmetic surgery two stage consent process, with a two week cooling off period between the two stages, was not regularly practiced. Patients provided written consent at the time of admission for surgery. Furthermore, when a patient changed their treatment a new two week cooling off period was not always initiated.
- We were not provided with assurance that consultants using their own cameras for photography were abiding by the hospital's policy for storing and handling patient photographs securely.
- There was a lack of assurance cosmetic surgery patients were being considered and referred for psychological review when it was needed.
- There were a large number of gaps with the previous year's staff appraisals and therefore some staff had not received an appraisal for two years.
- There was not an effective governance framework or strategy to support delivery and good quality care.
- There was poor management of risks. Departmental risk registers were not evidenced to allow risks to be managed at a local level.

Summary of findings

- Hospital wide clinical and internal audit arrangements were inconsistent in their regularity and accuracy. There was no audit at departmental level to allow individual actions to be identified.

However:

- Safe practice was observed and evidenced in the diagnostic imaging department and practice was in line with regulations.
- Staff were aware of their responsibilities to report incidents and safeguarding.
- Staffing levels ensured patients received safe care and treatment.
- Multidisciplinary team working was evident and staff respected each other's practice.
- All staff were observed to provide good care to patients which was friendly and compassionate. Patients were kept involved and informed and included in the decision making process. Staff ensured patients understood their care and treatment.
- The outpatient and diagnostic imaging service was organised to meet people's needs.
- The outpatient department identified areas of innovation and improvement to develop the service and the demands of the local population.

Summary of findings

Contents

Requires improvement

Mount Stuart Hospital

Services we looked at

Surgery

Outpatients & diagnostic imaging

Summary of this inspection

Background to Mount Stuart Hospital

Mount Stuart Hospital is an independent hospital and part of the Ramsay Hospital Group. The hospital is located in Torquay and opened in 1984 and serves the local population. It treats NHS and privately funded adult patients; including self-funded and medically insured. The hospital underwent a refurbishment and extension in 2015 and 2016.

Surgery, and outpatient and diagnostic services are provided at the hospital. Day case and inpatient surgery specialties included general surgery, major and minor orthopaedic surgery, ophthalmology, ear nose and throat surgery, gynaecology, urology, dermatology, endoscopy and cosmetic surgery. The hospital has 26 inpatient beds and 12 ambulatory care spaces. There are three main operating theatres, one day case theatre, and a recovery area.

Outpatient and diagnostic services are delivered in consulting rooms and include orthopaedics, general surgery, gynaecology and obstetrics, cosmetic surgery, ear nose and throat, urology, oral and maxilla, ophthalmology, gastroenterology, dermatology, and facial surgery. Diagnostic imaging services include plain x-ray, ultrasound, and fluoroscopy, magnetic resonance imagining (MRI) and computed tomography (CT) are provided from a mobile unit. There was a private physiotherapy service for outpatients.

MRI and CT together with non-surgical cosmetic treatments delivered by the cosmetic suite were not inspected as part of this visit.

The registered manager and accountable officer for controlled drugs for Mount Stuart Hospital is the hospital's general manager, Jeanette Mercer, who has been in post since December 2009.

During the inspection we looked at surgery and outpatient and diagnostic imaging. We inspected the hospital as part of our routine comprehensive inspection programme for independent healthcare services. We carried out a comprehensive announced inspection of Mount Stuart Hospital on 6 and 7 September 2016, and an unannounced inspection on 15 September 2016.

Our inspection team

Our inspection team was led by:

Inspection Lead: Gail Richardson, Care Quality Commission Inspector.

The team included CQC inspectors including a pharmacy inspector and imaging inspector, an Inspection Manager, and clinical specialists: a senior nurse, and two theatre managers.

Why we carried out this inspection

We carried out this inspection as part of our scheduled in depth inspections of independent hospitals.

How we carried out this inspection

We asked the following five questions of every service and provider:

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

Summary of this inspection

To carry out this inspection we used a variety of sources of information. The organisation provided us with data, statements and evidence prior to our inspection. This followed a request to the organisation from CQC for a range of information.

We visited the hospital on Tuesday 6 September and Wednesday 7 September 2016. We returned for an unannounced visit on Thursday 15 September 2016. We met and spoke with patients, a number of their relatives and supporters. We talked with a range of staff including the registered manager, the matron, the chair of the Medical Advisory Committee, and Heads of Department.

We held focus groups and drop in sessions for staff in the hospital to attend. We talked with doctors, the nursing staff, physiotherapy staff, and members of housekeeping, administration and support staff.

We inspected all areas of the hospital looking at the core services of surgery, and, outpatients and diagnostic imaging. We observed care in theatres, outpatients, and on the in-patient and day-case ward. We reviewed policies and procedures, training, and staff records and patient records. Mount Stuart Hospital runs as one unit and team with governance structures covering all aspects of the hospital and many staff working in multiple areas of the hospital. Therefore, some sections within the cores services are repeated throughout this report.

Information about Mount Stuart Hospital

Mount Stuart Hospital is an independent hospital and part of the Ramsay Hospital Group. The hospital is located in Torquay and opened in 1984 and serves the local population. It treats NHS and privately funded adult patients; including self-funded and medically insured. The hospital underwent a refurbishment and extension in 2015/16.

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What people who use the service say

Patients and relatives spoke highly of the care they had received and were complimentary about the care and treatment provided to them.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

- The management of incidents did not consistently follow the hospital policy. The management of duty of candour was well understood by staff but its implementation not consistently practised after an incident had occurred.
- There was a lack of up to date service level agreements with acute NHS hospitals for the transfer of patients requiring critical care.
- Not enough staff were directly employed by the hospital to staff the theatres and so 44% agency and bank staff were being used at this inspection. Theatre staff were unaware of which skills agency staff had, but, action had been taken to address this by the time of our unannounced inspection.
- Infection prevention and control practice was not in line with best practice. Hazardous waste was not managed safely and the flooring in consulting rooms and patient rooms was non-compliant with guidelines for infection control, not always cleaned, and had not been risk assessed.
- Clinical audit arrangements were inconsistent with no consistent departmental actions or timescales. Some aspects of clinical audits scored consistently low with no improvement in scores being demonstrated.
- Some areas of the theatre and ward environment required review including the emergency call system in recovery. The management of damaged equipment made its replacement prolonged.
- There was no clear resuscitation procedure in response to a medical emergency. Resuscitation scenarios had not been practiced in the hospital since July 2014. Fire evacuation drills had not been practiced in over a year and had not taken place since the opening of new theatres and ambulatory care.
- There was a culture of reporting and learning from incidents throughout the hospital.
- The matron was safeguarding lead for the hospital with support during working hours from the Ramsay Hospital Group safeguarding lead. Safeguarding practices were clear, and staff were aware of the actions needed if they had concerns. Staff told us about examples of appropriate safeguarding referrals.
- There was good handover of patients between staff and staff contacted and discussed the patient's condition with consultants when required.

Summary of this inspection

Are services effective?

Requires improvement

- Information about outcomes of patient care and treatment was not routinely collected and monitored for all patients.
- Assessment of nutrition and hydration were not consistently completed and so risks to patients were not always identified.
- Consent for cosmetic surgery was not in line with company or national best practice.
- Audits were not regularly completed. Actions seen as a result of audits were not followed up to ensure they had been completed
- Staff appraisals were not always completed which meant staff were not provided with an opportunity to review their skills, performance and development.
- Treatment was in line with best practice guidelines and staff applied this to their practice.
- Practising privileges for consultants were up to date and monitored regularly and any changes responded to.
- Multidisciplinary team working was evident between staff of different roles and from different departments to deliver effective patient care

Are services caring?

Good

- Staff were professional, kind and attentive with a focus on individualised patient care.
- Patients were kept informed at all times and included in their plan of care, this included discharge arrangements which considered the patients home circumstances. Patient's privacy and confidentiality was respected at all times.
- Feedback from patients was positive about staff and the service they received at the hospital. Patient questionnaires indicated high levels of patients would recommend the service and a high number of patient comments were positive.
- Staff recognised how they could provide emotional support for patients including identifying anxieties and responding to put the patient at ease.
- Patients were individually supported when intimate examinations were taking place with a chaperone. The availability of a chaperone for any patient was well advertised in patient facing areas.

Summary of this inspection

Are services responsive?

Good

- Services were planned to meet patients' needs. The hospital was meeting referral to treatment time guidance, patients had the flexibility to arrange a suitable appointment time, and the flow of patients from pre-admission through to discharge was well organised.
- The individual needs of the patients were identified and considered when delivering the patient pathway. Staff had time to explain to patients how their care would be delivered and so patients were well informed about their treatment.
- In theatres, staff were able to respond to the needs of patients out of normal working hours through the use of an on call team. Extra staffing was requested dependant on the workload.
- Complaints were managed effectively and investigations were inclusive of all individuals associated with the complaint. Clinical complaints were overseen by the matron. Learning from complaints and actions were shared with the appropriate individuals.
- There was no clear process for releasing staff from their normal duties if they had been called in or worked longer shifts.

Are services well-led?

Inadequate

- The vision and strategy for the hospital was not clearly defined. Not all services had a strategy for their department.
- There was not an effective governance framework or strategy to support delivery of good quality care.
- Governance processes were not in place and clearly defined to monitor services. Audits were not completed with regularity, actions not always followed up, and there was a lack of audits at a departmental level to identify specific issues.
- There was not a complete and accurate systematic programme of clinical and internal audit to monitor quality systems and identify action. Audits were not regularly completed and the results available were not regularly reviewed to ensure they were adequate. Actions seen as a result of audits were not robust or followed up to ensure they had been completed.
- Since our previous inspection in March 2016, the planned changes in governance, risk management and quality by the provider had not been actioned at a suitable pace to ensure patient safety.
- There was no effective system for identifying, capturing and managing issues and risks at a local department level. Staff were unaware of hospital or departmental risks. Staff were unsure of how to escalate a risk to the risk register and risks were not managed or reviewed at a departmental level.

Summary of this inspection

- Clear departmental management was not evident in all departments to ensure safe practice. Staff meetings did not always take place and what was discussed was not always written down for staff to review.
- The corporate values, 'The Ramsay Way,' were understood and demonstrated by staff.
- Staff were positive about their departmental managers and the hospital management team. Staff felt management were visible and approachable.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement

Requires improvement

Surgery

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

Information about the service

Surgery services at Mount Stuart hospital provide routine, non-urgent elective surgery for adults. The patients have to meet eligibility criteria to ensure their safety, NHS patients are assessed on a criteria and privately funded patients are reviewed on an individual basis. Surgery was not considered appropriate for patients who were assessed as potentially needing a higher dependency of care post-surgery. Surgery was not provided for patients below the age of 18 years.

The surgery service included three main operating theatres and one day case theatre, three have a laminar air flow ventilation system in place. The inpatient ward has 26 beds and is staffed 24 hours a day. There is an ambulatory care area with 12 spaces which is open 8am to 8pm Monday to Friday. There is a further day case theatre unit with three rooms open 7.30am to 8pm Monday to Friday.

The theatres were open for sessions Monday to Saturday between 8am and 8.30pm. There were 4,925 inpatient admissions including day care recorded at the hospital between July 2015 and June 2016, of these 81% were NHS funded patients and 19% were self-funded or medically insured patients. The surgery provided included general surgery, orthopaedic surgery, ophthalmology, ear nose and throat surgery, gynaecology, urology, dermatology, endoscopy and cosmetic surgery.

The five most common procedures performed at Mount Stuart between April 2015 and March 2016 were:

- Diagnostic endoscopic procedures with biopsy and forceps (453 episodes)
- Ultrasound phacoemulsification of cataract with lens implant (370 episodes)
- Diagnostic colonoscopy with biopsy and forceps (305 episodes)
- Total hip replacement (212 episodes)
- Total prosthetic replacement of knee joint (150 episodes)

The hospital employs 115 contracted staff including clinical staff, nurses, physiotherapists, radiographers, support staff, administration staff, hotel services and porters. There were 103 consultants registered with practising privilege arrangements in place to practise at Mount Stuart Hospital.

The provider stated in the Provider Information Return, 'In total we admitted 324 patients who were classified as 'Medical Admissions'. As this is not a core provision, our systems do not capture a classification for the admission.' The provider has clarified that medical admission was care provided as part of step down, rehabilitation or respite care following surgery.

During our inspection we visited all surgical areas, including main and day case theatres, ambulatory care areas, recovery areas and the surgical ward. We spoke with five patients, one relative of a patient and approximately 15 staff. These staff included consultant surgeons, consultant anaesthetists, nurse managers and nurses in a variety of roles. We also spoke with allied health professionals including physiotherapists and the pharmacist. We spoke with administrative staff and housekeeping staff.

We observed care being provided to patients and reviewed seven sets of patient records.

Before and after our inspection we looked at information about the service and data provided.

Requires improvement

Surgery

Summary of findings

We rated surgical services as inadeqaute overall because :

- The management of incidents did not consistently follow the hospital policy; more serious incidents were not always investigated properly. Duty of candour was understood by staff however, its implementation was not consistently practised after an incident had occurred.
- Mandatory training was not fully compliant. Compliance across the whole hospital (including employees booked onto a course) was 89.8%. The theatre staff mandatory training level was 76% and ward staff had achieved 88%.
- Medicine systems were mostly safe, however the storage of fluid and temperature monitoring required action to ensure safety.
- The amount of staff having completed their safeguarding training was requested but was not provided. Therefore we were not able to confirm the exact level of staff completing the training.
- The management of infection control showed that not all staff were fully trained, monitoring was limited and cleaning audits were not fully completed.
- Some areas of theatre and ward environment were in need of review, these included the completion of the theatre development programme underway and an emergency call system in recovery. The management and process of replacing damaged equipment was prolonged.
- Agreements with local trusts for the transfer of patients in an emergency were out of date and required update and agreement.
- The WHO checklists were not consistently audited to provide assurance they were correctly and fully completed. When shortfalls were seen, actions were not followed up to ensure improvements were made.
- Anaesthetic audits did not prompt remedial action to be recorded. The action plans undertaken as a result of the audit did not prompt change of practice.
- Records maintained of the deteriorating patients early warning scores (EWS) had been audited and shortfalls found. No follow up audit had taken place to ensure patient safety. Training for staff had been put in place but had not been evident in changing staff practice.
- Auditing of VTE did not evidence change in practice and showed deterioration in completion of a section relating to the post surgery review of prophylaxis by the surgeon. There were not sufficient actions or reviews taking place to ensure patient safety.
- Cosmetic surgery services did not follow the company policy. Psychological reviews had not been considered, recorded or undertaken to ensure that appropriate consideration had been given around body image and patient expectations.
- Resuscitation scenarios as a practice exercise had not taken place since July 2014. A resuscitation team had recently been implemented and part of their role was to plan and produce these scenarios. This had not yet taken place and training for this role was not planned until November 2016.
- No fire drill had been completed in the previous 12 months, this included the opening of new theatre and ambulatory care.
- There were not enough whole time equivalent staff employed by Ramsay Health Care to staff the three theatres and so an at this inspection 44% of agency and bank staff were being used.
- The outcomes for patients care and treatment is not always monitored. Clinical audits were not fully completed to ensure an effective service was being provided. No audits of cosmetic surgery were taking place.
- Staff did not always have the complete information they needed to provide care and treatment. Assessment of nutrition and hydration were not always completed using the malnutrition universal screening tool (MUST) and so risks to patients could not always be identified. Audits of nutrition and hydration were not available to assess service provision.

Requires improvement

Surgery

- There were gaps in support arrangements for staff. Not all nursing and ward staff had received an annual appraisal of their skills and performance.
- Consent for cosmetic services was not always obtained or recorded in line with in line with company and national guidelines. Timescales for consent were not followed to ensure all patients had a two week cooling off period between initial consent to surgery and the consent on the day of surgery.
- There was not a complete and accurate systematic programme of clinical and internal audit to monitor quality systems and identify action. Audits were not regularly completed and the results available were not regularly reviewed to ensure they were adequate. Actions seen as a result of audits were not robust or followed up to ensure they had been completed.
- The information used to monitor performance was not used to change and improve practice. Governance of areas reviewed by the Clinical Governance Committee which required an action plan did not all have timescales for action to be completed. Governance systems did not drive a change in quality of service.
- Quality and safety were not the top priority for leadership. The MAC was poorly attended and there was no evidence that minutes were read by members who did not attend.
- Theatre management and leadership was not evident at all levels to ensure safe practice. Some areas of leadership were not clear in the scope for their service delivery.
- Issues that impact on clinical care were not identified and adequate action to manage them was not always taken. There were no local risk registers in place and no department ownership of how risks were identified and managed. Risks were not used to prompt actions.
- Next day cover for the out of hours on call theatre team, should they be called in, was not in place.
- The Ramsay staff survey highlighted low staff scores around local and corporate leadership which indicated shortfalls in management.

However:

- The hospital promoted a culture of reporting and learning from incidents.
- Safeguarding practices were clear and the majority of staff we spoke with were aware of the actions needed if they had concerns.
- The sterile equipment for theatre was well managed, effective and audited to ensure a safe service was provided.
- Treatment was provided in line with national guidance and staff were aware of the relevant National Institute for Health and Care Excellence (NICE) guidance.
- Some national audit information about patients care and treatment and their outcomes was collected and monitored.
- Patients received treatment which considered their levels of pain
- With the exception of cosmetic surgery records, records showed consent to care and treatment was obtained in line with legislation and guidance.
- Feedback from patients was positive about the way staff treated them. Patients confirmed staff were professional, kind and attentive. Staff were seen to be kind and caring and their focus was on individualised patient care.
- Patients were encouraged to be involved in decisions about their care. Patients were kept informed at all times about their plan of care. The handover of information between staff included the patient and was inclusive of their views. This included both the admission and discharge process. Patient's privacy and confidentiality was respected at all times.
- Patients' anxieties were assessed and monitored to ensure patient was as comfortable as possible.

Requires improvement

Surgery

- Services were planned to meet patients' needs. The flow of admissions and discharges through the hospital were well organised. Patients were kept informed of any disruption to their care and treatment.
- The needs of different patients were considered in the planning and delivering of the service. Further work was needed to develop dementia care as part of the service.
- Discharge arrangements considered the patients home circumstances and care arrangements. This included patients being allowed to stay longer to ensure an effective discharge.
- Complaints were all responded to in a timely manner by the hospital manager and learning from complaints was demonstrated
- Waiting times were well under the guidance threshold of 18 weeks.
- The corporate values were understood by staff and included in induction and staff were aware of a local strategy in theatres.
- Since the inspection an appropriate response has been received following the issue of a requirement notice for good governance.

Are surgery services safe?

Requires improvement

We rated surgical services as requiring improvement for safety because:

- The management of incidents did not consistently follow the hospital policy; more serious incidents were not always investigated properly. Out of the five incidents we reviewed, two did not have root cause analysis completed. Duty of candour was understood by staff however, its implementation was not consistently practised.
- Mandatory training was not fully compliant. Compliance level was whole hospital (including employees booked onto a course) 89.8%. The theatre staff mandatory training level was 76% and ward staff had achieved 88%.
- Medicine systems were mostly safe, however the storage of fluid and temperature monitoring required action to ensure safety.
- The management of infection control showed that not all staff were fully trained, monitoring was limited and cleaning audits were not fully completed.
- Some areas of theatre and ward environment were in need of review, these included the completion of the theatre development programme underway and an emergency call system in recovery. The management and process of replacing damaged equipment was prolonged.
- Agreements with local trusts for the transfer of patients in an emergency were out of date and required update and agreement.
- The WHO checklists were not consistently audited to provide assurance they were correctly and fully completed. When shortfalls were seen, actions were not followed up to ensure improvements were made.
- Anaesthetic audits did not prompt remedial action to be recorded. The action plans undertaken as a result of the audit did not prompt change of practice.

- Records maintained of the deteriorating patients early warning scores (EWS) had been audited and shortfalls found. No follow up audit had taken place to ensure patient safety. Training for staff had been put in place but had not been evident in changing staff practice.
- Auditing of VTE did not evidence change in practice and showed deterioration in completion of a section relating to the post surgery review of prophylaxis by the surgeon without sufficient action or review taking place to ensure patient safety.
- Cosmetic surgery services did not follow the company policy psychological reviews had not been considered, recorded or undertaken to ensure that appropriate consideration had been given around body image and patient expectations.
- Resuscitation scenarios as a practice exercise had not taken place since July 2014. A resuscitation team had recently been implemented and part of their role was to plan and produce these scenarios. This had not yet taken place and training for this role was not planned until November 2016.
- No fire drill had been completed in the previous 12 months, this included opening of new theatre and ambulatory care.
- There were not enough whole time equivalent staff employed by Ramsay Health Care to staff the three theatres and so at this inspection 44% of agency and bank staff were being used.

However:

- The hospital promoted a culture of reporting and learning from incidents.
- Safeguarding practices were clear and the majority of staff we spoke with were aware of the actions needed if they had concerns.
- The sterile equipment for theatre was well managed, effective and audited to ensure a safe service was provided.

Incidents

- In the timescale April 2015 to March 2016 there were 72 clinical incidents, out of these incidents 65% (47) occurred in surgery or inpatients. Of these incidents 59 were categorised as no harm, five were categorised as low harm, seven were categorised as moderate, one was categorised as severe and none were categorised as a death. An overview of incidents were discussed at clinical meetings. Any trends which were appearing in incidents at a local (hospital) and Ramsay wide (corporate) level were reviewed at these meetings.
- In the last 12 months April 2015 to March 2016 , there were eight serious injuries/incidents in total in the hospital. Serious incidents were categorised by the incident policy as grade 1 and examples we reviewed included complications during surgery and adverse reactions after surgery.Clinical incidents and serious incidents prompted root cause analysis investigations. All incidents particularly serious incidents were discussed at Clinical Governance Committee and minutes were held however there was no clear documentation of outcomes and what learning should be taken from the incidents.
- There was awareness by staff of how to report an incident and all said they were confident in using the electronic system of recording used by the hospital. Incidents were coded using the Ramsay corporate coding where one was the most severe and four the least severe. The policy noted that for severity one and two a root cause analysis would be prompted by the electronic recording system. We reviewed five incidents in this category, and we saw that two did not have a root cause analysis completed.
- Investigations into incidents were reviewed and cascaded by matron and delegated to the appropriate head of department for investigation and to formulate the response. Staff involved in incidents and investigations were asked to complete a reflective practice to ensure learning was identified and undertaken to minimise incidents happening again.
- In the last 12 months there have been no Never Events. Never Events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- An incident policy was in place, the policy was last reviewed in August 2012 and had just expired the next review date at the time of inspection. The policy

highlighted to staff the approach to incident reporting and the responsibilities of staff in incident investigation. Incidents were reviewed over the last year. There was a range of incidents reported from both clinical and non-clinical areas which varied in severity.

- There had been no expected or unexpected inpatient deaths at Mount Stuart in the previous timescale April 2015 to March 2016. If deaths did occur these would be reviewed and discussed at the Clinical Governance and Medical Advisory Committee (MAC) meetings and lessons learned would be highlighted and shared.
- Staff spoken with demonstrated an understanding of the duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the provider to be open and transparent with a patient when things go wrong in relation to their care and the patient suffered harm or could suffer harm which falls into defined thresholds.
- The Ramsay corporate policy for duty of candour was included in the 'Being Open Policy.' This provided guidance on being open and referenced the NHS standard contract requirement for duty of Candour stating that 'notification to be at most within ten working days of the incident being reported.' The policy stated that a written response should follow any discussions had in person.
- The provider did not follow their own policy as they did not always record discussions or the apology. We looked at three incidents in detail which were classified under the Ramsay policy as requiring a duty of Candour response. There was no initial written record of a verbal apology or record of how the investigation process was to proceed or how the patient was supported after the event.
- Staff told us they had received training on duty of candour, however figures demonstrating how many staff had attended were not available.

Safety thermometer or equivalent

- Some patients at Mount Stuart hospital were funded by the NHS so the national patient NHS safety thermometer was used to look at safety issues related to pressure ulcers, falls, venous thromboembolism (VTE), and catheter associated urinary tract infections. For all NHS patients one day each month of data was submitted to the NHS. The results of the safety thermometer were reviewed at the clinical governance meetings and the MAC meetings.
- For patients who were privately funded and so not monitored under the NHS safety thermometer, these safety issues were monitored through the hospital's audit process

Cleanliness, infection control and hygiene

- The provider had in place infection prevention and control policy which was in date, last reviewed in March 2015. Matron was the lead for infection prevention and control for the hospital. The infection control lead for Ramsay was available for advice but did not visit the hospital on a regular basis and had last visited in July 2016.
- Patients were risk assessed for infection risk in outpatients as part of the key health questionnaire prior to their surgery.
- In the timescale April 2015 to March 2016 there were no incidences of Methicillin Resistance Staphylococcus Aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA), Clostridium Difficile and Escherichia coli.
- In the timescaleApril 2015 to March 2016 there were three surgical site infections resulting from knee operations giving a rate of 2.3 per 100 patients. The infection control link nurse was responsible for monitoring surgical site infections, they would ensure patients returned feedback on their wound 30 days following patient discharge to allow for surgical site infections to be identified. The surgical site infections were reviewed and did not identify any trend or links.
- Infection and prevention audits were not consistently used to monitor the service. A surgical site infection audit had been completed for March2016, with 94% compliance. A further surgical site audit took place in May 2016 with 99% compliance. No further surgical site infection audits were available.
- We saw the infection prevention and control committee minutes from the 10 February 2016 which noted there was no infection prevention audit on a rolling programme. The infection control meeting minutes from April 2016 stated the rolling programme was

reviewed and showed February 2016 surgical site infection audits compliance 99%. However, no surgical site infection audit was provided to us for February 2016.

- Hand hygiene audits were completed for July 2015 and December 2015 which scored mostly 100%. In April 2016 100% compliance was achieved, however this was only based on three staff members which is a poor representation of staff hand hygiene throughout the hospital. Hand hygiene audits were recorded hospital wide and did not identify by area where the checks had taken place. This did not enable feedback by area of any issues. We asked the ward staff about hand hygiene audits and they confirmed they had taken place. We asked senior theatre staff if hand hygiene review had taken place in theatre and they had no record or recollection.
- The hospital's most recent patient led assessment of the care environment (PLACE) scores were lower than the England average for cleanliness. At the time of inspection significant work had taken place at the hospital. Areas looked clean and cleaning staff were seen to be on duty each day.
- An infection prevention and environmental audit had taken place in November 2015 and February 2016. Issues around carpets and furnishings and storage of waste products were seen on both audits and both had an action plan for completion of April 2016. We saw at this inspection some issues remained around carpet cleaning and some storage of waste products remained ongoing.
- Some areas of the ward had carpet which was not as easily cleaned as the laminated flooring when spills occurred. There were cleaning rotas in place and we spoke with housekeeping staff who explained the carpet cleaning procedures both in work hours and out of hours. There were no immediate plans to remove carpets from patient rooms and replace with flooring which posed less of an infection risk. The issue of infection control and carpets was not on the risk register. Housekeeping staff were responsible for cleaning carpets with a steam carpet cleaner which was currently broken. At the time of inspection the cleaning staff told us they were without a steam carpet cleaner for 11 days, although a hire machine was available. By the end of the unannounced inspection new equipment had arrived and training had been provided. There was a six month rolling programme of deep clean.
- There were two permanent cleaning staff and two bank cleaning staff. They worked two shifts to cover the morning and evening. The increase in the size of the hospital after the renovation resulted in more areas to clean. There had not been an increase in cleaning staff and so the extra bedrooms and ambulatory care had to be cleaned by the existing staff.
- Cleaning of theatres was undertaken by porter staff and a rota was in place. The increase in theatre size had not included a plan to increase cleaning by porters. Subsequently the extra cleaning had been undertaken by theatre staff. We saw cleaning records were in place but not filled in by either the porters or theatre staff. These records were for before theatres being used and in between procedures. Theatres were cleaned at night by porter staff. No audits of cleaning rotas were being undertaken to ensure there were no issues.
- Mandatory training for infection control stated that face to face training currently achieved 84%;No e-learning data was available due to an IT system change over.
- The sterile equipment for theatre was provided by the Mount Stuart sterile services department on site. This was seen to be well managed, effective and audited to ensure a safe service was provided.
- We saw staff followed hospital procedures for infection prevention and control and were bare below the elbow and used personal protective equipment and hand gel. There was a lack of storage for scrub clothing and the area was dusty. There was no shower curtain to enable staff privacy to shower.

Environment and equipment

- The monitoring of theatre equipment did not consistently ensure a safe environment for patients. We saw in theatre two that one of the mattresses for the operating table was damaged and posed a risk of injury and cross infection. We reported this immediately to senior staff who confirmed the next day the mattress had been decommissioned and a new one ordered. We were later told by theatre staff that it had been identified but there was a delay in ordering. We

discussed with senior management staff that theatre cleaning staff had not identified this as an issue previously. Further verbal reminders for theatre cleaning staff were implemented by hospital management to ensure damaged equipment was promptly reported on a daily basis.

- We requested audits of theatre equipment but these were not undertaken. This would enable staff to have a clear picture of equipment available and the current state of repairs needed. When equipment was in need of repair a two tier system of ordering was in place dependent on the price of the order. There were delays seen in ordering equipment. For example a theatre fridge was ordered, but staff were not told this fridge was not available so the order sat delayed until staff requested more detail and were told of the reason. They were then able to reorder from a list of obtainable fridges. This meant equipment replacement was delayed.
- Daily equipment safety checks were undertaken in theatres by the Operating Department Practitioner (ODP). This included checks of oxygen cylinders. The anaesthetic machines had a daily recorded check from the ODP but not from the anaesthetist prior to use. Theatre staff confirmed the anaesthetists undertook the checks but did not record them. Theatre staff did not audit records to identify and record the reason for any gaps. This may pose a risk if those checks had not taken place.
- Staff confirmed that equipment and implants used were in line with the Medicines and Healthcare products Regulatory Authority (MHRA) requirements and should faults or problems be identified, feedback was provided to both the equipment provider and the health care products regulator. There were audits of implants used and a record of all prosthesis used. There was a recording implants register and data supplied to the National Joint Registry of procedures and equipment used.
- The storage of equipment was seen to be on large mobile shelving. The shelves containing equipment trays were above head height and so would pose a moving and handling risk to staff to lift them off safely.
- There was no local risk register in place for staff to record and review any local identified equipment or environment risks and ensure actions were monitored and actioned.
- There was a framework in place for health and safety in theatres; however a clear plan for implementation and inclusion of staff was not yet in place. A health and safety lead was now employed in theatres and risk assessments had been implemented. At this time there was no evidence of interaction with theatre staff for the dissemination of issues related to health and safety for learning. We were told the example of the damaged operating theatre mattress would not have been considered as a learning exercise or used to proactively make change to drive improvement.
- The hospital's PLACE scores were lower than the England average for condition appearance and maintenance. Prior to our inspection significant work had been undertaken to the hospital. The hospital looked to be clean and in a good state of repair.
- We were not aware of the use of Health Building Notes being used to guide the infection control within the new building works.
- The development of the theatre areas had not been fully completed. Some areas remained in need of finishing, these included wires in the ceiling outside recovery. A snagging list was being formulated to address these issues.
- Sinks were available in the bathroom of each ward bedroom. Staff confirmed they used these for hand washing and used paper towels to hand dry. This use of sinks for both patients and staff may pose a risk of cross infection. A hand wash sink was also available on the ward should the sink be in use. The temperature of bedrooms was not monitored. Fans and portable heaters were seen to be available if needed.
- We saw resuscitation equipment available in each area of the hospital including the ward, theatres and recovery. The trolleys were checked daily and all portable equipment had been serviced within the last year.
- The X-Ray gowns and lead aprons were hung one on top of the other (three to four gowns), which should all be

hung separately. On the second day of our inspection, we saw they were hung two gowns over each other. This area had been checked by the radiography staff three weeks previously.

- A hoist was available for the safe moving and handling of patients. The hoist could safely hold patients with a body mass index (BMI) of up to 40. Should a patient require moving in excess of that BMI, then alternative hoists would need to be sourced. Senior staff confirmed that no patients were admitted who may need the alternative hoist.

Medicines

- A pharmacist had been in post for six months and provided clinical support to theatres and the ward on two days a week. Prior to the pharmacist starting work at Mount Stuart, staff were without a permanent pharmacist for one year following closure of the in-house pharmacy. During that time the service had two long-term locums in place.
- Medicines, including emergency medicines, were available to people when they needed them. Doctors prescribed medicines on prescription and administration charts.
- Medicines were generally stored correctly, however we saw the temperature of some areas used to store medicines was not recorded, although the rooms were air conditioned. The temperature of the treatment room in the ambulatory care unit was recorded as out of range since 1 August 2016, which was as far as records went back. The records showed that although the actual and minimum temperature varied each day, the same maximum temperature had been recorded every day. Staff explained they did not know how to reset the thermometer. No action had been recorded as being taken to address this.
- Allergies were recorded in the patient care record and on patient individual drug charts.
- Staff described how they report medicines errors and the pharmacist explained they had oversight of all medicines errors.
- The ward manager explained how nurses dispensed medicines in the treatment room during the night shift, for people to take home the next day. These medicines were left in baskets on the worktop for other nurses to check. Although the treatment room was locked, it was accessible to all staff. During the inspection, staff made arrangements for medicines waiting to be checked to be stored in a locked cupboard.
- Since the pharmacist had been in post, prescribing, controlled drug and medicines management audits had been completed. The June 2016 controlled drug audit showed 87% compliance with all actions, the May 2016 prescribing audit showed 76% compliance and the April 2016 medicines management audit showed 64% compliance. The pharmacist had plans to work with the matron to develop an action plan regarding the areas where improvements needed to be made, including adherence to hospital policy around the use of unlicensed medicines. The hospital matron was the "Accountable Officer" for controlled drugs and had overall responsibility for ensuring appropriate destruction of controlled drugs
- Fluids were stored in a locked cupboard. We saw that the fluids were marked with expiry dates, all expiry dates were before the date at the time of inspection. The deputy ward manager did not know why these fluids were stored when expiry dates had passed. We reviewed this practice with staff and nobody could provide a definitive reason for this practice.
- The hospital provided a blood transfusion policy and training for staff for the issuing of blood units. The hospital had a lead nurse for blood transfusion training. Blood units were bar coded but no scanning facilities were available so all checks were done manually by staff before blood was administered and the temperature of storage recorded daily.

Records

- Each patient had a care record; this was a booklet for either day or longer stay surgery. The records included all preadmission assessment, investigations and results and risk assessments. This document was used to ensure that patients met the safe criteria to have treatment at the hospital. Once admitted, the records included a pre-operative checklist, anaesthetic room care, care during the procedure and recovery care. Post procedure each day had risk assessments, interventions and outcomes recorded. All entries were signed and dated by staff. Patient's length of stay was in the majority of cases, no longer than four days.

- Patient medical record audits had taken place in January 2016 and July 2016. The January 2016 audit showed issues about a lack of GP referral letters in the notes but stated they were available elsewhere, poor dating and timing of entries by all grades of staff, a failure to sign formal delegation to support workers, the need for pre-admission calls in the department needed to be reviewed, and surgeons needed to record activities as part of the procedure more comprehensively. The action plan was recorded as 'to be raised with staff and results of audit shared with non-medical and medical staff and responsibilities discussed' with a completion date of 31 March 2016.
- The July 2016 audit was seen for 10 sets of records. Some areas scored 100% including the patients name and details. Some areas scored 0% and these included the surgeon recording each time they had seen the patient and staff recording the date and their signature on all entries. The area 'Details of Consultant letter to the General Practitioner according to locally agreed standards or contract guidance, but no longer than 4 weeks' also scored 0%. The date and time of all procedures was not seen to be consistently recorded (60% completed) and identification of any prosthesis used, including the serial numbers of prostheses and other implanted materials was not consistently recorded (50%). For day-case patients a phone call to the patient has been recorded within 48 hours of admission to confirm admission and discharge plan scored 0%. Since the previous audit in January 2016 improvements were not recorded as having been made. No action plan was seen to address these issues. No further audits had taken place and no update to the action plan seen. We reviewed the clinical governance meeting minutes and this audit was discussed but no further actions were recorded.
- We reviewed seven sets of records and found them to be completed and readable. The records maintained of the patient's time in theatre were fully completed and included the World Health Organisation (WHO) safety checklist undertaken prior to surgery. We also saw the pre-printed discharge letters to GPs were ready for patient discharge. The date and time of procedures was recorded and included the identification number for any implant or prosthesis used.
- Each anaesthetist maintained a clinical record and these were stored in the patients' medical records held on site during any procedure and stored securely on site after treatment was completed.
- A policy was in place for the security of medical records outside Ramsay Healthcare facility, last reviewed October 2013. The policy advised staff of their responsibilities when removing records outside of Mount Stuart Hospital. Senior staff confirmed that the removal of notes by surgeons was not normal practice and was discouraged. Ward staff told us that no records had been removed in their recent memory. The risk register notes a risk of poor information security, confidentiality breaches and lack of accreditation to ISO27001. This noted on the risk register to be of a moderate risk and is due for review in August 2017.

Safeguarding

- A safeguarding policy was in place and accessible to all staff. Staff demonstrated a variable understanding of their safeguarding responsibilities and of safeguarding procedures. Some theatre staff demonstrated a limited understanding.
- The new matron was the safeguarding lead for the service. Updated level three safeguarding training was planned for the new matron but had not yet been completed. In the interim the previous matron continued to be available for any staff to contact, should advice be needed. The safeguarding lead for Ramsay Health Care was contactable in working hours and out of hours staff would contact the local authority safeguarding lead for advice. Senior staff at Mount Stuart Hospital told us the safeguarding lead for Ramsay who they would contact was the nominated individual and was trained to level five.
- All qualified nurses and allied health professionals completed level two safeguarding training for adults as part of their induction and mandatory training. This was a two part training with part A consisting of e-learning being completed every three years, and part B which included Deprivation of Liberty and Mental Capacity Act awareness for staff for who have responsibility for planning patients care and treatment and did not

include health care assistants. A flow chart was on the ward wall to inform staff of actions to take to raise an alert and further guidelines were available for staff in the nurse's office.

- The amount of staff having completed their safeguarding training was 76% for theatre staff. Of the ward staff, 88% had either completed or booked onto mandatory safeguarding training.
- There had been one safeguarding concern reported to CQC in the reporting period April 2015 to March 2016. Staff were able to describe a safeguarding incident and the actions they had taken.
- Female Genital Mutilation (FGM) was included as part of the safeguarding policy. Staff confirmed training was provided as part of their safeguarding training, the issue had not been raised at the service, however, staff we spoke with were confident of recognition and actions to be taken.

Mandatory training

- Mandatory training included basic and intermediate life support, fire safety, moving and handling, infection prevention, safeguarding vulnerable adults and children, and mental capacity act and deprivation of liberties safeguarding. Each area of the hospital kept their own training plan and knew what training was required or planned for the year. This was with the exception of theatre where there were no local training plans to establish when staff should receive training.
- The provider target for mandatory training was 90%. The theatre staff mandatory training level was 76% and ward staff had achieved 88%. There was no information on the target set by the hospital for mandatory training compliance. At the time of the inspection the current system did not allow the hospital to run an automated report of both e-learning and face to face learning per module and member of staff.
- Ward staff had completed intermediate life support training and the resident medical officer (RMO) had completed advanced life support training. A rolling update plan was seen to be in action to ensure all staff were up to date. The Ramsay policy expects all staff administering sedation to update their immediate life support training annually to enable them to renew their practice and privilege agreement.

Assessing and responding to patient risk

- Prior to admission all patients including day case patients were seen in the outpatients department. A series of risk assessments were completed including VTE, nutrition and risks of skin damage and falls. On admission the risk assessments were reviewed and repeated and the patient was asked if any changes had occurred since the key health questionnaire had been completed. All results from pre-operative investigations were reviewed to indicate suitability for surgery. The hospital did not provide care and treatment for patients who had complex needs or needed care which the hospital's staff could not safely provide.
- The service for each patient was consultant led for both day surgery and inpatient admission. Pre and post-surgery the consultant saw the patient and remained on call to respond should there be need to contact them. We observed staff calling the consultant when they had concerns.
- Out of hours the consultant was called if needed should there be complications or the patient deteriorate. The MAC lead confirmed there was no set time for the consultant to get into the hospital. However, most consultants were local and it was their responsibility to provide cover should they be unavailable. In the interim the resident medical officer (RMO) was available to provide medical support. An escalation procedure was in place should a patient deteriorate, nursing staff would escalate to the RMO who would in turn escalate to the consultant. The RMO confirmed that should the timescale for the consultant to arrive exceed what they felt was safe for the patient, an emergency ambulance would be called.
- Post-surgery the provider did not have facilities or staff with suitable training to care for patients classed as level two where patients have higher dependency needs. Should an increased level of dependency unexpectedly occur, which staff could not meet safely, the patient would be transferred to the local acute trust. Should a transfer need to take place between hospitals, a service level agreement with the local trust was in place. This agreement was out of date and had not been reviewed since 2013. The service level agreement was in the process of being amended by the matron and the changes had not yet been ratified by the management

at Mount Stuart Hospital or finally signed off by local trust. We were aware that in one instance the patient was transferred to a trust a further distance away. There was no service level agreement in place with that trust.

- The theatre staff followed the five steps to safer surgery. This involved following the World Health Organisation (WHO) checklist before, during and after each surgical procedure. We visited anaesthetic rooms and theatres and saw the WHO checklist completed on each occasion. A thorough team brief was completed prior to the start of each list. Specific WHO checklists were in place for cataract surgery to ensure all areas of risk were covered.
- The WHO checklists were not consistently audited to provide assurance they were correctly and fully completed. When the three audits identified shortfalls actions taken did not prevent reoccurrence. We saw only three WHO audits for the previous 12 months, September 2015, February 2016, and July 2016. We looked at the WHO audit for February 2016 of ten sets of records, which scored 100% on all outcomes. However, this audit was not signed or dated to say who completed it and when. There were no follow up comments from any previous audit and no comments from this audit. Ten sets of records were reviewed in each case. In the September 2015 audit all areas achieved 100% except 'all areas requiring times, initials and signatures are recorded and are legible', which scored 60%. This gave the audit an overall score of 93% but did not give due significance to the identified 60% shortfall. The action in place was 'individuals responsible for omitting time on the sign out will be spoken to and this will be raised as an agenda item at the next theatre team meeting.' This had a completion date for October 2015. No staff team minutes were available for that timescale to see if the action was discussed. We reviewed the audit completed in July 2016 which scored 97% overall and the same issue noted as a shortfall in September 2015 scored 90% which was one set of notes not including the sign out signature.
- The theatre manager confirmed no WHO audits had been completed to ensure a review of patient safety. We were told that 'no formal observational audits of the WHO checklist were completed in theatres but as the theatre management staff are part of the surgical team practice is observed on a daily basis'. We revisited the hospital as part of the unannounced inspection and were provided with the WHO audit for August 2016.The August 2016 audit noted that the time was missing from the sign out. We were told by senior staff that the new matron would be providing an overview to theatre audits.
- Anaesthetic audits did not prompt remedial action to be recorded. The action plans undertaken as a result of the audit did not prompt change of practice. We reviewed the anaesthetic standards audit which had been completed six monthly. Ten sets of records were audited and for September 2015 all scores were 100%. Despite achieving 100% an action arising was 'anaesthetic equipment checked prior to list by every anaesthetist but not documented however this can be added to the machine check books'. We reviewed these records during the inspection and saw gaps were still evident where the checks had not been recorded. We were told a further audit had taken place in August 2016. This audit had highlighted that anaesthetic records did not record patient consent, action was being taken to address this. It had also been observed that anaesthetists were not prescribing oxygen given to the patient. This was now being addressed and the oxygen being written as a prescription.
- There was a theatre organisational management audit undertaken September 2015 and July 2016. In the September 2015 audit most areas achieved 100% with an overall score of 94%, however, the area 'Records of swab, needle and instrument counts (x3) are signed as completed within patient records', scored 80%, an action was put in place to remind the scrub nurse to sign for the swabs. Six areas scored zero on the audit. Action plans were recorded to address these issues. In the January 2016 audit, these areas appear to have been addressed.
- The theatre perioperative audits undertaken identify no call bell system in recovery, this was not remedied nine months later. There was a theatre perioperative care audit for October 2015 which scored consistently 100% and there was an anaesthetic standards audit September 2015 which referenced the Association of Anaesthetists of Great Britain (AAGBI) standards. All scores were 100% for all areas. The audit commented 'no emergency bell, if help is required it is a verbal shout however there will be emergency call bell system in the new recovery currently being built.'. We reviewed this at

inspection and saw an emergency call bell system had not been fitted as part of the new theatre building work. Staff told us they could ring the nurse call which sounded in recovery only and would shout through to theatre. A further perioperative audit was undertaken in July 2016 which noted no emergency bell in recovery that links to any clinical area. The action plan noted 'Discuss provision and functioning of emergency bell in recovery with engineers and ensure that it links to other areas in the department'.

- A theatre clinical effectiveness audit was completed in May 2016. The areas covered included accountable items, fluid management and tourniquets. Most areas scored 100% however some shortfalls were found. There was a lack of information on the outcome, 'where the surgery is known to exceed six hours in duration there is evidence of a local risk assessment to ensure that the scrub practitioner and circulators can practice for the duration of the case, or that there is a planned handover of care.' When asked the hospital told us they did not undertake operations which lasted 6 hours or more and so this area of audit was not applicable. A shortfall was 'the intraoperative fluid balance (positive or negative) is recorded on the fluid balance chart in the correct place.' This had not been completed in any of the five records reviewed. An action plan was put in place and was written as 'audit outcome to be shared with theatre MD' and 'no risk assessment of >6 hour opsre scrub nurse tc though it is rare to have such loing proceudres'. This was how the action plan had been written by the staff member, and was not a clear action for staff to follow.
- The provider used Early Warning Scores (EWS) to monitor for triggers of sepsis and staff had received training on using the scoring to recognise sepsis. The sepsis action pathway was available in each patient's notes on the back of the EWS record.
- Audits of Early warning scored demonstrated that recording and observations and actions taken were not consistently recorded and this placed patients at risk. Audits would indicate that observations were not completed; calculated, recorded and appropriate action may not have been taken to ensure identification of a deteriorating patient. Training for staff had been put in place but had not been evident in changing staff practice.
- We reviewed two audits for the deteriorating patient November 2015 and March 2016. It was not evident if the records sampled for the audit included patients whose health had deteriorated, to ensure systems had been used correctly. In November 2015 ten records were reviewed, the recording of early warning scores (EWS) only 60%of the notes had been calculated for each set of the observations.
- The deteriorating patient audit in March 2016 showed that only 50% of the notes had been calculated for each set of observations The level of calculation was needed to initiate the track and trigger flow chart and scores showed the records were not fully completed when this action was needed. Only 78% of records showed the correct person had been contacted according to the track and trigger flow chart.
- Since this audit took place staff had started to attend a critical care study day. The action plan 30 April 2016 was 'as part of the role out of the EWS Chart re-education on completing the charts will be given'.
- We reviewed seven sets of patient notes and saw observations had been completed in each case. Calculation of scores had not always been completed and so it was not possible to see how staff were using the scores to identify patient deterioration.
- Cosmetic services were provided but not all areas of risk had been considered. We saw from two cosmetic surgery records that psychological reviews had not been considered, recorded or undertaken to ensure that appropriate consideration had been given around body image and patient expectations.
- A corporate resuscitation policy was in place, last reviewed March 2016. Resuscitation scenarios as a practice exercise had not taken place since July 2014. A resuscitation team had recently been implemented and part of their role was to plan and produce these scenarios. This had not yet taken place and training for this role was not planned until November 2016. The resuscitation team was manned by four staff during daytime hours and two staff out of hours. In daytime hours this included the RMO and the nurse in charge, the anaesthetist and ODP in theatre. Out of hours this was the RMO and nurse in charge. Each member of the resusitation team carried a bleep to alert them if needed and these were tested weekly.

- Should a patient require an unplanned and unexpected return to theatre and it was out of normal working hours there was an on call theatre team rota. The ward staff would contact the team who consisted of the consultant, anaesthetists and three staff members. Staff confirmed they were called in three times in the previous year.
- Auditing of VTE did not evidence change in practice and showed deterioration in completion of a section relating to the post surgery review of prophylaxis by the surgeon without sufficient action or review taking place to ensure patient safety. Ten records were audited for September 2015 and had an overall score of 91%. The section 'VTE prophylaxis has been reviewed by the surgeon post surgery (as evidenced by a completed VTE review section on the operation note)'scored 50%. In February 2016 the scores for most areas were 100% with an overall score of 94% however for the question 'VTE prophylaxis has been reviewed by the surgeon post-surgery (as evidenced by a completed VTE review section on the operation note) had a score of 57%. In March 2016 the overall audit score was 89% and the section 'VTE prophylaxis has been reviewed by the surgeon post surgery (as evidenced by a completed VTE review section on the operation note)' scored 25% Two audits took place in May 2016, one for surgery and one for cosmetic surgery. No other audits were seen to have taken place. The two May 2016 audits continued to show a deterioration.
- The VTE policy was last reviewed 2014. The policy states that an audit must be undertaken quarterly, this had not been consistently done. No further audits had taken place and no update to the action plan seen. We reviewed the governance meeting minutes and this issue was discussed but no further actions recorded.
- There had been no recorded VTE incidents and no record of feedback to Ramsay through the Integrated Governance report of any VTE incidents.
- We looked at seven sets of records and saw a risk assessment had been completed for each patient and a plan for VTE prophylaxis. We did not see any post-operative review of VTE.
- We saw within the policy a Ramsay Recommended Prescribing Guidance for VTE Risk Patients. We spoke with the MAC chairman who confirmed that VTE procedures were agreed procedures and any variance was agreed with the MAC. The MAC chairperson was not aware of any Ramsay VTE policy in place and considered VTE procedures to be in line with local trust protocols.
- Pressure area care assessments were completed pre operatively and every two to four hours post operatively. Gel heel and hip pads were available specifically for hip and knee patients and any elderly patients. Early mobilisation was encouraged for patients and any assistance needed to change position in bed was provided.
- A further issue was 'staff have undergone training in the safe use of all tourniquet equipment and there are documented competencies and records of achievement.' An action plan was 'discuss assessment of tourniquet use with lead anaesthetist/surgeon'. No further audits had taken place to identify if these issues had been addressed.
- There were no interventional procedures undertaken on site, only joint injections and barium studies.
- A telephone contact line was available for all patients discharged. This enabled them to ring the hospital, both day and night, with any concerns.

Nursing staffing

- Ward staffing was managed daily to ensure sufficient staff were available. Ward staffing levels were calculated using Ramsay's staffing guidance and reflected the number of patients and their dependency. Staff were rostered via Ramsay's electronic health roster system with rosters reviewed on a daily and weekly basis, against patient activity and staff availability. Ward staffing was discussed and evaluated at each staff handover meeting to ensure staffing was safe. The ratio basis used was 1:5 registered nurses to patients in the day and 1:7 at night. We observed the ward manager reviewing staffing for the next day and saw the staffing levels identified as necessary to be in place. We saw planned levels of staffing were met. Variable levels of agency staff had been used on the inpatient ward between April 2015 and March 2016 to cover staff sickness. However, there were no agency nurses and health care assistants working in inpatient departments

in the last three months of the reporting period (April 2015 to March 2016). Bank staff were used on the ward and staff reported all bank staff worked frequent shifts to maintain their competence.

- Each day a senior nurse was on duty at all times on the ward. The senior manager on call provided telephone advice and, where required, would attend the hospital.
- The provider told us the theatre department utilised AfPP (Association for Perioperative Practice) guidelines in determining staffing levels whilst also taking into account the surgical speciality. Staff were rostered via Ramsay's electronic health roster system which automatically rostered the number of staff required per shift a month ahead from a pre-set template. The provider told us that the theatre management identified staffing requirements a week ahead and monitored this daily. We spoke with the theatre management, who were unclear of the staff allocation, how many theatre staff they should have compared to how many staff they actually had and more specifically how many staff were needed for each procedure. This meant that staffing levels and skills were not identified for each procedure. The theatre rota was done each Thursday for the following week.
- There were not enough whole time equivalent staff employed by Ramsay Health Care to staff the three theatres. A recruitment drive had not been fully successful in filling all vacancies and so the hospital used bank and agency staff in the interim. There was a shortage of permanent theatre staff, the theatre manager was unclear the exact figure of that shortage. Staff confirmed that whilst theatre capacity had increased, staffing levels had not increased accordingly and so agency and bank staff were needed.
- Agency usage in theatre department was high. On the morning of the first day of our inspection there were 12 staff in total in theatre and recovery. These were a mix of nursing and ODP staff. Of the12 staff, there were six Mount Stuart staff, one bank member of staff and five agency staff on duty. This equated to 56% contracted staff and 44% combined bank and agency staff of which 12% were regular bank staff. On the afternoon there were nine staff on duty of which five were Mount Stuart staff, three were agency staff and one was bank. On the second day of our inspection there were 12 nursing staff on duty in the morning of which three were agency and two were bank staff. In the afternoon there were eight staff on duty, of which two were agency and one was bank staff. Of the agency staff used in those two days some were used regularly. For the week of the inspection two agency staff used were there for five days of the week. One agency staff was there for two days and four agency staff were only there for one day.
- The provider used a regular agency provider, however the theatre management was not aware of the skills of the agency staff. This meant that the management could not confirm those staff skills were sufficient to ensure patient safety. On the unannounced part of the inspection, this had been addressed by the agency being requested to provide details of staff skills to ensure senior staff had the appropriate information for all theatre staff.
- At the time of our inspection there were sufficient recovery staff to meet the planned theatre activity. Two trained nurses were seen in recovery when all lists were running. Only one was available when one list was running.
- Should a patient need to return to theatre out of hours, there was an on call theatre team, which included a scrub nurse and two ODP staff. They rotated the on call each week and had to be within a 30 minute radius. The patients consultant and anaesthetist were also on call for the duration of the patients admission. Staff told us that should they be called in at night, there was no facility to cover their shift the next day and they would be expected to work. Staff told us this did happen but was very rare.
- Physiotherapy staff had been working short of their full staff compliment since 2015. Recent recruitment and change of leadership have meant improvements for the physiotherapy team.

Surgical staffing

- All surgery was consultant delivered. This meant consultants were responsible for their own patients 24 hours a day seven days a week. It was the responsibility of each consultant to cover their own absences and ensure the person they appointed to cover for them had the appropriate skills and practice and privilege agreement in place. There were 103 consultants working under practice and privilege arrangements covering a variety of surgical specialities including orthopaedic and

cosmetic surgery. The provider checked as part of the practice and privilege arrangements that the surgery each performed was what was undertaken in their usual place of work.

- The cosmetic surgeons working at the hospital were fully qualified members of the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) and the British Association of Aesthetic Plastic Surgeons (BAAPS).
- Each consultant and anaesthetist saw their own patients pre and post operatively and were available on call until the patient left the hospital, this may mean overnight or for several days and included out of hours and weekends.
- The anaesthetist involved with the patients surgery was also on call for the duration of their stay. Should they become unavailable it was their responsibility to provide anaesthetic cover for any unplanned returns to theatre. Should they be found in those circumstances to be unavailable, the MAC advised the duty anaesthetist at the local trust would be contacted. No anaesthetic on call rota was in place.
- The resident medical officer (RMO) was provided by an outsourced agency and was available on site 24 hours a day for the period they were on rotation usually one or two weeks. The RMO in place was new to the hospital and had been in post for ten days. They explained they had received an induction and had shadowed the previous RMO for two days prior to taking over the role. The RMO told us they had access to support by telephone to the RMO agency should they have any questions or concerns and these would be discussed and appropriate advice provided. Should there be any concerns about the RMO other hospital staff would discuss with Matron, who had the RMO supervisory role.
- The RMO worked with the senior member of staff on duty on the ward. The RMO, RMO International and the hospital senior staff maintained a watching brief on the RMO's hours with RMO international maintaining details of average working hours of each RMO per shift. Any concerns would be raised with matron.

Major incident awareness and training

- The provider had in place a business continuity management plan, last reviewed September 2013 and had just expired next review date at the time of inspection. This policy stated, 'Staff shall be trained on the emergency procedures and process, including Incident Handling, Business Continuity and IT Disaster Recovery, both when they are initially appointed to a position, and as part of ongoing training and regular testing'. We spoke with the lead staff member for Health and Safety who confirmed this was the case.
- Fire alarms were tested weekly; a full fire drill had not taken place in over one year, with the last drill in August 2015. No drill had been completed in theatre since the new theatre had been commissioned. A full drill was planned within the next four weeks of the inspection date with theatres undertaking a desktop exercise to prevent any disruption to theatre lists.
- The hospital has an emergency generator which provides back up for 30 hours. The maintenance manager checked the generator weekly with monthly testing, we reviewed evidence of these tests being completed.
- There was no security overnight. Any concerns would prompt staff to immediately contact the police. CCTV was at the nurse's station and the hospital doors were secured after 6pm. Access to the building was by intercom and supervised by staff.
- Theatres were locked at night with keys stored securely. Should theatre need to be open at night the keys were available for staff.

Are surgery services effective?

Requires improvement

We rated that surgical services as requiring improvement for effective because:

- The outcomes for patients care and treatment is not always monitored. Clinical audits were not fully completed to ensure an effective service was being provided. No audits of cosmetic surgery were taking place.
- Staff did not always have the complete information they need to provide care and treatment. Assessment of nutrition and hydration were not always completed

using the malnutrition universal screening tool (MUST) and so risks to patients could not always be identified. Audits of nutrition and hydration were not available to
- assess service provision.
- There were gaps in support arrangements for staff. Not all nursing and ward staff had received an annual appraisal of their skills and performance.
- Consent for cosmetic services was not always obtained or recorded in line with in line with company and national guidelines. Timescales for consent were not followed to ensure all patients had a two week cooling off period between initial consent to surgery and the consent on the day of surgery.
- However:
- Treatment was provided in line with national guidance and staff were aware of the relevant National Institute for Health and Care Excellence (NICE) guidance.
- Some national audit information about patients care and treatment and their outcomes was collected and monitored.
- Patients received treatment which considered their levels of pain
- With the exception of cosmetic surgery records, records showed consent to care and treatment was obtained in line with legislation and guidance.

Evidence-based care and treatment

- Audits included length of stay, complications, readmission, and return to theatre, cancellations and transfers. Commissioning for Quality and Innovation (CQUIN) both national and local were completed with 100% achieved in 2016.
- Local clinical audits were planned to be completed in line with Ramsay's audit programme and results were shared at the local Clinical Governance Committee and scrutinised by the Corporate Clinical Team; they also formed part of the integrated monthly governance reporting to Ramsay Corporate and Clinical Commissioning Group. We saw audit completion was not fully or regularly undertaken or reviewed.
- Patients undergoing hip and knee surgery consented to their data being submitted to the National Joint Registry (NJR). Data was submitted to enable monitoring by the NHS of the performance of joint replacements.
- National Institute for Care Excellence (NICE) guidelines were sent to all consultants and heads of department on a quarterly basis. Ramsay corporate policies, documents and clinical audits were based on NICE guidance as appropriate. All care pathways were evidenced based and related to the most recent national guidance. For example, care was provided in line with NICE CG50 Acutely ill patients in hospital: recognising and responding to deterioration with early warning scores being used.
- VTE prophylaxis for post-operative patients was recommended as per NICE guidance CG92 to reduce the chance of post-operative complications (which can be severe or on occasion result in death) such as Deep Vein Thrombosis or Pulmonary Embolism , the review of VTE prophylaxis by the consultant post-surgery was part of the Ramsay policy. We saw from audits a lack of assurance that actions noted as part of these audits, demonstrated an improvement in scores.
- Cosmetic surgery practice was not monitored to ensure practice was in line with the Professional Standards for Cosmetic Practice-Cosmetics Surgical Practice Working Party, Royal College of Surgeons (RCS Professional Standards). There was no audit to monitor compliance to the RCS Professional Standards to provide assurance regarding compliance and to identify any areas for improvement. Psychological evaluation and support was not provided as part of the cosmetic surgery service at this hospital.
- The theatre manager was not clear about what audits were being completed. These included cleaning audits for theatre, hand hygiene audits for theatre, equipment checklist for theatre, patient temperatures and pain audits in recovery. We saw some audits had been completed, however some remained incomplete. We fed this lack of audit understanding to the registered manager at the end of our second day of inspection.
- The hospital participated in the Patient Led Assessment of the Care Environment (PLACE) audit annually.

Pain relief

- We saw pain relief was discussed pre-operatively, in recovery and on the ward. Post-operatively the level of the patient's pain was monitored using a pain score card (0-10 pain score, with 10 being the highest level of pain) and recorded in their records. Whilst in recovery, pain levels were monitored and the patient was only moved back to the ward when pain was controlled. Recovery staff gave pain relief as prescribed by the consultant.
- Five patients we spoke with confirmed they were comfortable and pain relief was well managed.
- There was no link pain nurse or specialist pain service to provide advice and support if needed. A link pain nurse is a nurse with specialised knowledge in pain management. Advice could be obtained from local acute trust specialist pain team. Pain relief was prescribed for patients being discharged home.
- We saw patients mobilising post-surgery. Pain relief was prescribed to prevent pain impacting on recovery. We saw as required medicines were prescribed appropriately and recorded when given.
- Controlled drugs were stored, administered, recorded and disposed of correctly. Prescription forms were stored securely and there was a tracking system in place. Nurses administered medicines in a safe manner and signed the prescription and administration chart as appropriate or recorded the reason why people had refused to take medicines. People on the ward described how they received all their medicines and could call for staff if additional pain relief was needed.

Nutrition and hydration

- The malnutrition universal screening tool (MUST) was not consistently undertaken to risk assess each patients level of risk. No nutrition and hydration audit results were available to us to establish nutrition and hydration had met patients' needs. Ward staff told us an audit had just been competed but the results not uploaded to the hospital audit system. At pre assessment, any special diets were identified.
- Instructions about pre-operative starvation times (nil by mouth) was given during the patients pre-admission visit. Patients were advised that solid food could be taken six hours before surgery and fluids two hours prior to anaesthetic. As patient admission times varied, we did not see that alternative advice was provided to ensure patients did not starve for extended periods of time. Staff checked as part of pre procedure checks when the patient last ate or drank and this was recorded in the patients care record.
- We saw at pre-assessment, a recorded discussion about post-operative nausea. This would enable medical staff to review how this would be managed.
- Intravenous fluids were prescribed post-surgery, however, none were prescribed at the time of inspection and so no records were available for our review.
- The provider told us that a dietitian was attached to the outpatient department. However, should advice be needed, staff told us they would contact the local trust for advice. The ward manager had implemented staff huddle meetings which included discussion about nutrition and hydration.
- The hospital's PLACE scores were the same or higher than the England average for food, organisational food and ward food.

Patient outcomes

- The Hospital uploaded data to the National Joint and Ligament Registries and Patient Related Outcome Measures, Hip and Knee patients (commenced Jan 2016).
- For Patient Reported Outcome Measures (PROMS), Mount Stuart Hospital for April 2014 to March 2015 for groin hernias showed groin hernias were within the estimated range of the hospital's score.
- For hip procedures , primary hip replacement was within the estimated range. The Oxford Hip Score recorded out of 155 records, 96% were reported as improved and 2% as worsened. The Oxford Hip Score is a patient reported outcome measure (PROM) developed to assess function and pain in patients undergoing total hip replacement surgery.
- For knee procedures The Oxford Knee Score is a patient reported outcome measure (PROM) developed to assess function and pain in patients undergoing total hip replacement surgery.
- There were no audit results available for cosmetic surgery.

Competent staff

- The provider had a clinical supervision policy in place, last reviewed January 2012 and had exceeded its next review due for January 2016. The policy framework said for all staff to participate in one to ones, group or peer supervision, so to enhance patient care. The policy did not indicate the frequency of the supervisions to be provided.
- Nursing staff appraisals were not completed for all staff. The theatre management assured us all theatre staff had received appraisals. Ward staff appraisals remained ongoing.
- The management team were clear that all consultants registrations were in date and they were only performing surgery they were able to evidence they were sufficiently skilled to do. Human resource systems were in place to alert the administrative team when professional registrations were due for renewal and the consultant's appraisals were requested and recorded.
- Review of requirements for practising privileges was monitored by the hospital's director and human resources manager. When a consultant was due their appraisal they would receive written advice asking them to provide the required detail. A period of three months after the due date would be allowed but if the appraisal documentation was not received then the consultant would be suspended. Any complaints or incidents relating to the consultant would also be reviewed as part of the process.
- Expiry dates for professional insurance indemnity were also tracked with letters being sent to remind consultants to submit the documents. Should the document not be produced within one month the consultant would be suspended from practice until the document was made available.
- We reviewed six sets of medical staff records all of which contained two professional references, proof of professional registration, GMC registration, indemnity cover, appraisal documentation and DBS checks.
- Where a consultant wanted to add a procedure to their practising privileges they were required to evidence they were undertaking the procedure in another hospital then submit to the Medical Advisory Committee for approval. The MAC chairman would review the submission and a discussion would take place to decide if the new practice could commence.
- Staff told us induction training was comprehensive to ensure they were suitably competent.
- Ward staff told us they attended training, records in each department confirmed this but the systems in place at management level did not allow for all training to be routinely and easily collated. Theatre staff confirmed that human factors training was not part of their training schedule to support safe practice.
- Agency and bank staff confirmed they undertook an induction and training to ensure they were competent to work at Mount Stuart. An orientation checklist was in place for agency staff to compete when they started work at Mount Stuart Hospital. Following our announced inspection systems had been put in place to ensure theatre managers were assured that the agency staff had sufficient skills required for their role. Information about agency staff skills and qualifications were to be sent to the theatre manager to ensure that allocation of staff was suitable to match staff skills.
- Surgical first assistants were enabled to attend with the surgeon. However, this was not possible until all the checks had been completed and the human resources office had completed the appropriate security checks.

Multidisciplinary working (in relation to this core service only)

- Staff told us there was good communication between departments with good handovers of patient information. There was communication between nursing and allied health professionals to support patients with pain relief, appropriate moving and handling and arrangements for discharge. The daily meeting enabled a discussion of any multidisciplinary work needed.
- The consultant handed over any information they felt relevant to the RMO before leaving the hospital. We saw that when needed the RMO contacted the consultants at home. We also saw ward staff ringing the consultant when they felt there was a need to.
- Discharge planning was considered at pre admission and at each stage along the patient's pathway. Nursing staff liaised with families and carers on admission to

check there will be suitable care provision available before treatment started. The patient's GP and the consultant were able to speak by telephone to ensure a continuity and accuracy of information provided.

- On discharge each patient's GP received a letter including the treatment provided and details of any implants used. This letter was either transported by the patient or sent through the mail.
- Should the patient already have community support at home, nursing staff contacted the community teams including district nurses to update and ensure services recommenced.

Seven-day services

- The hospital provided elective surgery Monday to Saturday each week from 8am to 8pm. The type of surgery was dependant on which consultant was booked in for which day. Staff were aware of the patient lists one week in advance to enable staffing levels and rooms to be available.
- Nursing staff and the RMO were available to provide routine or urgent medical and nursing treatment 24 hours a day. A member of senior management was available to support staff as part of an on call rota.
- The surgical services were able to access support from other health care professionals out of hours. A radiographer was available and was contactable out of hours. There was access to a physiotherapist.
- Physiotherapists were working on the ward from 8.30 am until whenever they were needed. One physiotherapist was on the ward each morning and two each afternoon. We saw patients were supported to mobilise twice a day. Out of hours physiotherapy could be called for advice by the ward staff. There was on call physiotherapist available to be contacted every evening from 5pm until 7am.
- The pharmacy service was available two days a week. Outside of these working days the Ramsay Healthcare group pharmacist or pharmacist from the sister hospital could be contacted for advice. Should a prescription be required outside of those days a porter was sent to the local pharmacy to pick up the medicine.
- Should urgent diagnostic tests be needed, some blood testing facilities were available but outside of those tests, specimens would be sent to the local trust with a turnaround time dependent on how busy they were.
- There was an out of hours on call theatre rota available including the patient's consultant and anaesthetist should a patient need to return to theatre.

Access to information

- Patients had two sets of records whilst in hospital. One set of records remained at the nurse's station and had the consultant's notes and operation details, these notes were secured in an office. A further file was left in the patient's room and contained observations and letters relating to the patient. Patients had full access to those records.
- All the hospital's own records were kept on site, or recalled from a medical records store in time for their outpatient appointment.
- At the time of discharge, letters were completed and a copy remained in the patients notes and a further copy, sent to the patients GP. The letter would include details of procedure performed and any follow up plans.
- We saw that when patients were discharged, staff provided literature on the specific aftercare needed for their procedure and ensured patients understood the content.
- Should patients have any concerns when discharged they could telephone the ward for further advice and information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A consent policy was in place. The policy detailed how consent was to be obtained and the consideration of capacity to make an informed consent. The policy also included the use of removed tissue and the consent to photographs, filming or audio recordings. There was further detail about consent for blood transfusions and cosmetic procedures.
- Mount Stuart hospital senior staff told us the service rarely accepts referrals for patients who lack the capacity to consent. We saw seven sets of records and all showed the patients had capacity to consent. We saw consent records were fully completed and signed by the

consultant and the patient. The consent form also included a facility for a translator to sign to say what input they had provided and an area for signature of a witness should the patient not be able to sign but had indicated his or her consent.

- Consent was completed by the consultant at the pre-admission visit (consent form one) and again during the procedure preparation (consent stage two). We spoke with a consultant surgeon who confirmed this was the correct procedure. There was also a section in the patient's record to check the patient could demonstrate a clear understanding of the proposed procedure.
- For consent to cosmetic procedures consent should be obtained in a two stage process, a two week cooling off period was required to enable the patient to reflect on their decision. The hospital policy stated that 'should this not be possible, good reasons should be recorded in the patient's notes. Information on the procedure should be received at a different time to the signing of the consent form. Royal College of Surgeons April 2016'. We looked at records for two patients having undergone cosmetic surgery. The records did not state the cooling off period indicated to enable the patient to think about the procedure. Consent for the surgery was completed on the day of surgery. Should on the day of the surgery the patient or surgeon want to make changes this would mean a further cooling off period would be needed. The records included in both cases a record of discussion about the patient's expectations and any risks to the surgery. Staff explained that often the period between pre assessment and admission was considered to be the cooling off period and that should the patient not wish to continue they would not attend for admission. The consent form one and two were seen to not be signed prior to admission for both patients. Should on the day of procedure the patient decide to have a change in procedure or an alternative was discussed a further cooling off period would not be provided.
- Mandatory training was provided for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards as part of the part B safeguarding training. Specific detail of how many staff had completed this training was not available. Patients would be referred to their GP for an assessment if this was identified. The provider has a mental capacity policy which references the Mental Capacity Act and provides staff with a flow chart to follow should a patient be identified as lacking capacity. This policy was last reviewed in March 2015.
- The provider had in place a Deprivation of Liberty policy last reviewed January 2016. The policy described the procedures in place should the safeguards be needed. Staff told us this had never been used.
- Records of patient's choices for resuscitation were not kept. This was because the hospital's pre- assessment process for non-urgent elective surgery, considered all patients to be for resuscitation. The provider had in place a Do Not Attempt Resuscitation policy (DNAR), last reviewed March 2015. The policy informed staff of their roles and responsibilities. The policy for Mount Stuart was 'Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR.'
- We saw consent audits had been undertaken for September 2015, December 2015 and March 2016. Each time ten sets of records were audited. The results varied, in September 2015 extra procedures, photographs or blood transfusion (as known about pre-operatively) had been noted on the consent form in only 50% of the records. In December 2015 this was completed in 56% of cases and in March 2016 100% of cases. In December 2015 the question 'Has stage one of the informed consent process been initiated within a satisfactory period of time, to allow the patient to make a decision to proceed, or to ask further questions and to receive further information, to allow them to make an informed decision' only scored 60%, but in March 2016 this scored had improved to 100%.

Are surgery services caring?

Good

We rated surgical services as good for caring because:

- Feedback from patients was positive about the way staff treated them. Patients confirmed staff were professional, kind and attentive. Staff were seen to be kind and caring and their focus was on individualised patient care.

- Patients were encouraged to be involved in decisions about their care. Patients were kept informed at all times about their plan of care. The handover of information between staff included the patient and was inclusive of their views. This included both the admission and discharge process. Patient's privacy and confidentiality was respected at all times.
- Patients anxieties were assessed and monitored to ensure patient was as comfortable as possible.

Compassionate care

- Staff described 'The Ramsay Way' which includes all aspects of customer service. The values included being caring, progressive and positive and taking pride in what they do. To value integrity and respect the individual. To build constructive relationships, to achieve positive outcomes and value professional and personal development. We saw an example of this when we observed a porter who when noticing a patient's height exceeded the trolley length found a trolley extension to ensure the patient's comfort.
- There was a privacy and dignity policy in place, last reviewed September 2013. This provided staff with the scope of their responsibilities to ensure all patients were treated with privacy and dignity.
- We spoke with five patients who were complimentary about staff and the care they had received. They described staff as kind, caring and respectful. We observed staff knocked on doors before entering and addressed patients respectfully. We also observed that staff asked patients for consent before any activity.
- Staff provided reassurance for patients who were anxious and staff were calm, reassuring and supportive to patients. Individual patient preferences were taken into account. The most recent (June 2016) patient questionnaire confirmed for NHS patients 100% of patients felt they were likely to recommend the service. The only dip below 100% was for general surgery day case which dipped to 97% of patients likely to recommend. Comments received as part of the friends and family questionnaire were all positive with only two exceptions.
- The hospital's patient led assessment of the care environment (PLACE) scores were lower than the England average for privacy, dignity and wellbeing.
- A chaperone was available to all patients should they request this. A chaperone policy was in place last reviewed December 2014 which noted a chaperone facility was always available and should the patient not feel comfortable with the chaperone, alternative arrangements could be made.
- The NHS Friends and Family test (FFT) reviews the opinions of NHS patients using the service. The hospital's FFT scores were similar to the England average of NHS patients across the period October 2015 to March 2016. Response rates were below the England average of NHS patients apart from in December 2015. The Friends and Family report for April 2016 noted that for NHS day case and NHS inpatient almost all surgical areas scored 100% for likely to recommend the service. Only general surgery dipped below to 97%. In June 2016 all surgical areas scored 100% likely to recommend apart from orthopaedics which scored 94%.

Understanding and involvement of patients and those close to them

- Patients told us they were confident about their plan of care, knew what was planned for them that day and their ongoing discharge plans.
- At the handover between shifts the nurse in charge of that area went with the new staff member to the patient's room and handed over information about the patient, with the patient. The patients records were reviewed with the staff member and the patient. We saw the patient was included and their opinion sought. Their level of pain and satisfaction with the care provided were discussed. This enabled the patient to feel included and also be part of the information handover.
- Patients records included any discussions with them about treatment options and any comments or preferences to be considered.
- If the patient was not an NHS patient costs and fees were discussed at the pre admission visit to enable the patient to make an informed decision about continuing with treatment.

Emotional support

Requires improvement

Surgery

- We saw staff make patients comfortable, answer questions and ensure the patient was caused as little distress as possible. We observed on the ward staff spending time talking with patients and discussing any concerns they may have about discharge.
- The patient's anxiety was assessed as part of the admission process and any discussion recorded to ensure the patient was as comfortable as possible. This was monitored an included in the patient care record.

Are surgery services responsive?

Good

We rated surgical services as good for responsive because:

- Services were planned to meet patients' needs. The flow of admissions and discharges through the hospital were well organised. Patients were kept informed of any disruption to their care and treatment.
- The needs of different patients were considered in the planning and delivering of the service. Further work was needed to develop dementia care as part of the service.
- Discharge arrangements considered the patients home circumstances and care arrangements. This included patients being allowed to stay longer to ensure an effective discharge.
- Complaints were all responded to in a timely manner by the hospital manager and learning from complaints was demonstrated
- Waiting times were well under the guidance threshold of 18 weeks.

However :

- Patient theatre gowns were made of thin material and small in size.

Service planning and delivery to meet the needs of local people

- The general manager held discussions with stakeholders to review the service provided and looked at potential changes in the service to meet the needs of the local population.
- Patients were seen to arrive at two different times (morning and afternoon) to enable staff to manage admissions and to reduce the waiting times for patients.
- Staff in theatre and recovery told us they were flexible to stay late if needed. An on call out of hour's team were available, they would be called for an unplanned return to theatre. Should they be called in and have to work overnight, the day staff would try to get cover for them. Staff told us that should that not be possible they would work extended hours. No planned cover was in place to release them from their planned day.
- Ward staff told us that should the workload be anticipated as busy, extra staff would be requested. We saw the ward manager reviewing the next day's list to ensure sufficient staff would be available.
- Patients had access to a telephone in their rooms and access to internet to contact people outside of the hospital. Hospital rooms all had TV with remote control access to keep patients entertained.
- Each patient had a named nurse who they knew was caring for them each day. This ensured a continuity of care and enabled staff to hand over to the next person taking care of the patient. We saw that visiting was available for most of the day but longer visiting times were available for non NHS patients.

Access and flow

- There was an inclusion and exclusion criteria in place for NHS patients but not for non NHS patients. Staff said private patients were excluded on a case by case basis, dependent on the patient and the treatment they would receive. these were discussed at the patient's outpatient appointment. This ensured that the patient was considered safe to have surgery at Mount Stuart Hospital.
- The hospital met the advised 18 week referral time to treatment for incomplete and non-admitted patients.
- Patients admission times varied dependant on procedure but the longest length of stay was approximately four days. Patients could pay extra to remain longer should they choose to.
- Systems were in place to manage flow through the hospital. Following the pre-operative consultation in the outpatients department, a planned date for admission

was confirmed with the patient by letter. Any diagnostic tests required were done in the interim period. Should a change in procedure be needed, a further outpatient appointment was booked. The length of waiting time varied dependent on the consultant and the procedure.

- In the last 12 months there were five unplanned returns to theatre giving a rate of 0.08 per 100 visits to the theatre. On each occasion a notification was completed and any investigation required was completed and learning discussed at the daily staff meeting.
- In the last 12 months there were eight readmissions to surgery within 28 days giving a rate of 0.16 per 100 patients. The readmissions did not show any specific trends.
- In the last 12 months there were six unplanned transfers of inpatients to other hospitals giving a rate of 0.12 per 100 patients. The reasons for the transfers varied and did not show any specific trends. Most transfers were to the local NHS trust and links were in place to ensure an effective transition. We were made aware of a transfer to another trust because it was the consultant's normal place of work. We discussed this with the MAC chairman who did not consider this to be an unreasonable variation.
- When patients had to be cancelled, they were rebooked in a timely manner and a suitable time agreed. In the past 12 months there had been 535 cancellations.The provider assured us that the majority of cancellations were patient choice. All patients who still required a procedure were offered another appointment within 28 days. On the day of our unannounced inspection the morning theatre list had one patient listed for surgery. We were advised this was because a group of consultants were on a study day.
- The theatre management told us they did not have any insight into cancellations of surgery and the re-booking of procedures. However, we were advised a theatre representative attended weekly theatre utilisation meetings and increased or stood-down staff subject to activity. Ramsay had a theatre policy covering staffing levels and managers utilised an electronic rostering system, which listed all staff (contracted & bank) and auto-rostered template numbers across a month. Numbers were then adjusted in line with activity by a manager. The booking process was undertaken and a list provided for the theatre manager to provide the appropriate staffing and equipment.
- We observed the flow of patients to have some delays. In one instance there was a half hour delay because the anaesthetist had not seen the patient. Admission times varied and we saw that staff greeted patients and showed them to their rooms. Staff were responsive and no delays were seen in staff completing the admission process and assisting the patient to prepare for theatre.
- Discharge planning was considered at point of booking, it was also discussed with patients and relatives at pre-admission clinic or pre-operatively where patients did not attend a pre admission clinic, to ensure appropriate post-operative care arrangements were in place. We observed for one patient a longer inpatient stay was planned due to family not being available until a certain date to support the patient at home. The patients discharge was discussed with the patient to ensure plans at home had not changed.

Meeting people's individual needs

- Patients told us they were well informed about their treatment prior to admission and that staff had provided any further information they needed. There was a two stage recovery process. Patients had their first stage post procedure recovery whilst in theatre and then moved to the stage two recovery in the glass 'pod' area. For patients who had day surgery, they were admitted to a three bedded day case area, had their procedure in theatre and then returned from the recovery to the day case area unless they had a general anaesthetic; in that case they went to the glass 'pod' area.
- The hospital had lift access to each floor and wide corridor access for patients using a wheelchair or walking aids. For patients with visual or hearing loss signage was provided and hearing loop was available.
- Patient theatre gowns were made of thin material and small in size. This did not meet all patients' needs.
- Staff told us they rarely had any patients living with dementia, as the hospital was not a suitable

environment to provide that level of care. Should there be a case to admit a patient with dementia, their family member or carer was invited to stay with them free of charge.

- There were no patients who lacked capacity to make their own decisions admitted at the time of inspection.
- If a carer or patients relative who provided a support role wanted to stay at the hospital, that was enabled to ensure the patient was as comfortable and settled as possible. Staff told us that for patients with any learning disability of cognitive need, the carer could stay all day or remain overnight.
- We saw hot drinks were provided on request and relatives could also eat with the patients. There was a wide menu available with specialist diets catered for. For non NHS patients an alternative menu was provided which included a cooked breakfast.
- Patient theatre gowns were made of thin material and small in size. Staff and patients commented on this poor equipment, which did not fit the patient's needs.
- Staff told us should language be a barrier to ensuring consent they would access language services through language line. This meant staff would telephone the service and the patient would speak to the service who would interpret for staff. Staff were clear they would not use relatives for interpretation.
- Psychological support was available from an external service. Patients having cosmetic surgery should be considered for this service, we did not see any evidence of this. Patients having bariatric surgery were all offered this service.

Learning from complaints and concerns

- Patients told us they were well informed about their treatment prior to admission and that staff had provided any further information they needed. There was a two stage recovery process. Patients had their first stage post procedure recovery whilst in theatre and then moved to the stage two recovery in the glass 'pod' area. For patients who had day surgery, they were admitted to a three bedded day case area, had their procedure in theatre and then returned from the recovery to the day case area unless they had a general anaesthetic; in that case they went to the glass 'pod' area.
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- Psychological support was available from an external service. Patients having cosmetic surgery should be considered for this service, we did not see any evidence of this. Patients having bariatric surgery were all offered this service.
- The provider told us "we actively encourage patients to raise concerns in order that they can learn from them. Complaints and concerns are always listened to, taken seriously and responded to. Processes and systems are

in place to agree lessons learned and for sharing these to ensure improvements were made to care. For example, as a result of one complaint the process for chaperones was highlighted with a sign placed in the reception area to inform the wider public."

- A complaints policy was in place, last reviewed March 2016. The policy identified the actions to be taken should a complaint be made and the policy was accessible to staff.
- Information on how to make a complaint was available within a leaflet which set out the process and what people should expect. Two leaflets were available, one for NHS patients and one for premium care patients. The leaflet was not available in each bedroom but this was being considered by the ward manager. Currently the leaflets were available on request from the nurses' station. The provider advised that information was sent to every patient, both NHS & private, in their admissions booklet by the bookings team.
- In the last 12 months April 2015 to March 2016 the provider received 20 complaints. The reasons for complaint varied and included timescales from referral to procedure, treatment and communication and staff attitude.
- CQC directly received one complaint in the last 12 month period. One complaint had been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period.
- The hospital manager was responsible for ensuring all complaints were acknowledged in writing within two working days of the day on which the complaint was received. The registered manager signed all complaint letters. All those reviewed included an acknowledgement letter and response within the timescales set out in the policy. In some cases a wider investigation was undertaken, again with explanation of the findings and any actions. If the complaint involved any aspect of the clinical care of the patient the matron would lead on the investigation but would ensure the relevant head of department was fully involved and learning disseminated to hospital staff and if relevant corporately at the conclusion of the investigation. The complaints ranged in content but did not identify any specific themes.
- If the complaint involved a consultant with practising privileges then the hospital manager would meet with that individual to discuss the complaint, involving the Medical Advisory Committee Chairman as necessary.

Are surgery services well-led?

Inadequate

We rated surgical services as requiring improvement for well led because:

- The governance arrangements were not followed to ensure a complete overview of the service being provided. Governance systems did not drive a change in quality of service. The information used to monitor performance was not used to change and improve practice. Governance of areas reviewed by the Clinical Governance Committee which required an action plan did not all have timescales for action to be completed.
- There was not a complete and accurate systematic programme of clinical and internal audit to monitor quality systems and identify action. Audits were not regularly completed and the results available were not regularly reviewed to ensure they were adequate. Actions seen as a result of audits were not robust or followed up to ensure they had been completed.
- Since our previous inspection in March 2016, the planned changes in governance, risk management and quality by the provider had not been actioned at a suitable pace to ensure patient safety.
- There is a lack of clarity about leadership and decision making, quality and safety were not the top priority for leadership. Theatre management and leadership was not evident at all levels to ensure safe practice. Some areas of leadership were not clear in the scope for their service delivery.
- There was no effective system for identifying, capturing and managing issues at a local department level. There were no local risk registers in place and no department ownership of how risks were identified and managed. Issues that impact on clinical care were not identified and adequate action to manage them was not always taken. Risks were not used to prompt actions. At a

departmental level risks were not identified and addressed. The risks previously identified at the CQC March 2016 inspection were not included in detail the current risk register.

- Next day cover for the out of hours on call theatre team, should they be called in, was not in place.
- There had been development of theatre facilities but the provider had not been successful in recruiting to include an increase in theatre staff and cleaning facilities.
- There were low levels of staff satisfaction with leadership. The Ramsay staff survey highlighted low staff scores around local and corporate leadership which indicated shortfalls in management.

However :

- The corporate values were understood by staff and included in induction and staff were aware of a local strategy in theatres.
- Since the inspection an appropriate response has been received following the issue of a requirement notice for good governance.

Vision and strategy for this this core service

- The values for the hospital were called 'The Ramsay way'. These were corporate values. Staff had not been included in developing the vision and strategy for the hospital. The values were used in the staff induction to form part of staff training. Corporate information was accessible by newsletter.
- We spoke with staff that understood these values and spoke in positive terms about working for Ramsay Health Care and how they felt part of a family.
- Staff were aware of the local strategy for the development of theatres to enable an increase in theatre capacity. Staff understood that by building an ambulatory care area, an increase in day-case patients could be provided.
- There was no local clinical strategy in place for the hospital. This was planned to be developed with clinical staff by the Matron.

Governance, risk management and quality measurement for this core service

- Since our previous inspection in March 2016, the planned changes in governance, risk management and quality by the provider had not been actioned at a suitable pace to ensure patient safety.
- The governance processes in place to monitor the service provided were not used to make changes to the service. Information relating to governance, risk management and quality was communicated from the hospital to the senior management team through heads of department and management meetings. However, since the inspection an appropriate response has been received following the issue of a requirement notice for good governance.
- The Clinical Governance Committee met every two months and included the MAC lead and the matron. The meetings were required to be quorate, however we saw minutes of one meeting which was not. We looked at minutes for the meeting in June 2016 and saw it was chaired by the MAC lead and had five staff attending. Agenda items included review of incidents, complaints, update reports from clinical committees and policy updates. There was a summary of actions with a due date, but in each instance no dates for completion were included. The provider confirmed this was only required on completion and no update was required until that time. We saw that the audits we had identified as showing shortfalls were not followed up or commented on within the minutes of these meetings.
- Audits were not regularly completed in line with the company's own policy. Actions seen as a result of audits were not followed up to ensure they had been completed and low scores did not prompt further action. These included audits for VTE, infection control, early warning scores, cleaning, equipment, records and theatre audits.
- We saw meeting minutes for theatre staff and these included discussions about the 'Rectification plan' following the previous responsive CQC inspection. The plan was in place to address issues and requirement notices raised at CQC's previous inspection in March 2016. The minutes identified areas for development and noted there were no cleaning schedules available in theatre. At our inspection, cleaning schedules were in place but not completed and audits were still not

available. The minutes noted multiple equipment issues, no equipment audit was available when we inspected so there was no process in place to review if the equipment issues had improved.

- Risks were not used to prompt actions. . There was a corporate risk register in place with 22 open risks reported. All risks had been reviewed within the previous 12 months. Risks were split between financial (10), workplace health and safety (2), community expectations and reputation (3), patient safety and clinical care (3), facilities and equipment (3), leadership (1), environmental sustainability (1), workplace health and safety (1), legal and compliance (1). There was no local risk register in place for Mount Stuart hospital or any of the departments at the hospital.
- The majority of risks identified were related to corporate activities and of a financial nature. Local areas of the hospital, for example theatres or the ward, did not have local risk registers or ownership of their own risks.
- We spoke to heads of department who were not aware of the current corporate risks on the risk register and were not clear regarding how a local risk could be put onto the register. Heads of each department did not take part in reviewing the risk register or updating the risks on it.
- We were told the senior management team met weekly with the exception of days of heads of department meetings or bank holidays. Meeting minutes reviewed supported that approximately two meetings a month were held. We saw notes about new legislation and corporate policy updates being cascaded. We saw significant events/complaints/information security significant events and incidents being discussed.
- The Medical Advisory Committee (MAC) had a representative from surgical speciality and was an integral part of the governance structure. Facility rules were in place from Ramsay Health Care which included the composition of the MAC, terms of appointment and role specification which included the MAC role to participate in the plan and implement quality programmes. The MAC was led by a chairman. We reviewed the MAC meeting minutes provided for January 2016 and saw it was not well attended. The section of the minutes which discussed audits had a note 'clinical audit in hand'. This record did not note any discussion about audit results or shortfalls or plans for future audits. The MAC chairman did not consider review of clinical audits to monitor the quality of service provided part of the MAC role.
- We saw minutes from the Heads of Department committee meeting which recorded previous actions completed or ongoing and action plans as a result of the meeting taking place.
- Staff meetings did not take place regularly, the last theatre nurses' staff meeting was July 2016. Ward meetings had changed format to be a huddle twice a week with information and learning exchanged.
- There were no governance procedures for managing and monitoring any service level agreements the provider had with third parties. For example, the agreement for transfer with a local trust was out of date and not yet reviewed and completed. There was no agreement in place for transfer to a second local trust.
- Each day a meeting took place at 9am and a representative of all departments attended. The day's activities were discussed and this information taken back to each area and disseminated to staff. Handover of information took place at each shift change to ensure all staff were aware of the day's activities and plans.
- There were 103 doctors and dentists employed or practising under rules and privileges for the provider, all of which had their registration validated in the last 12 months. There were adequate consultants in post to meet the surgical needs of patients. Practising privileges were granted to consultants who agreed to practise following the hospital's policies and provided evidence of appropriate skills and registration. Most of the consultants worked in the NHS and so received their appraisal and revalidation there and the information was forwarded on request to Mount Stuart Hospital. The hospital had a responsible officer in post to ensure those consultants not employed elsewhere and for validation purposes were suitably appraised and revalidated.
- Expiry dates for professional insurance indemnity were also tracked with letters being sent to remind consultants to submit the documents. Should the document not be produced within one month the consultant would be suspended from practice until the document was made available.

- The hospital had Joint Advisory Group (JAG) accreditation for its endoscopy service. JAG accreditation is the formal recognition that an endoscopy service has demonstrated its competence to deliver against the measures in the endoscopy standards.
- Next day cover for the out of hours on call theatre team, should they be called in, was not in place. An on call out of hour's team were available, they would be called for an unplanned return to theatre. Should they be called in and have to work overnight, the day staff would try to get cover for them. Staff told us that should that not be possible they would work extended hours. No planned cover was in place to release them from their planned day.

Leadership / culture of service related to this core service

- The hospital senior management team consisted of the general manager, matron, operations manager, business development manager, finance manager and administrative lead. The general manager undertook the general running of the hospital and was supported by a regional director who visited the hospital monthly. Regional meetings took place monthly and provided support and an overview of service provision.
- Leadership at local level for surgery was the MAC chairman, the matron was the lead for nursing theatre, recovery and ward with heads of department in each area. The RMO was responsible to matron.
- At a hospital department level each department had a lead who reported to matron. Matron was new to post and staff were positive about the latest developments being considered. The heads of department met once a month and reviewed any issues, complaints and learning.
- Staff spoke positively about the leadership at a management, ward and department level. Staff told us they felt the divisional and board level leads were visible and approachable. We saw leadership of the ward by the ward manager was well organised and proactive. Leadership of the anaesthetic department was organised and proactive to meet patient's needs. Leadership of theatres lacked an understanding of governance and the use of audits to develop service and safe practice. The theatre department did not seem engaged or responsive to the service overall. For example, initiatives such as 'Hello my name is…' were seen to be in action by all staff except theatre staff.
- Recent changes in management had provided the physiotherapy team to be led by the aesthetics lead. This was a recent change and considered positive for the future.
- The clinical sterile services department was managed by the operations manager who was also the decontamination manager. This service was well managed and audited and had clear process to follow.
- Staff sickness had a percentage for the 12 month period of 7%. Mount Stuart Hospital remains the highest in the company group for sickness levels due to a number of long-term sick leave episodes.
- Staff turnover and recruitment for the previous 12 month period was 22%. Head of department meeting minutes stated that for the first time in four years, staff turnover had been above company average due to a number of reasons for staff not continuing employment.
- Should staff require a level of performance management, this was undertaken by the head of department with the support of Matron.
- The staff survey question my direct line manager actively supports my development, staff scored this 63%. Ramsay Health Care has a strong customer/patient focus, staff rated the response 100%, however for questions relating to leadership the responses were lower. For the question the corporate leadership team listen and act upon employee's views and concerns, staff scored 34%. For the question: The senior management team take the views and opinions of staff seriously, staff scored 49%.
- We spoke with staff who confirmed they felt respected and valued and enjoyed working at the hospital. We spoke with some staff who had worked at the hospital a long time because they enjoyed it. They said the hospital culture encouraged candour, openness and honesty.
- Staff spoke about their well-being check which was part of the Ramsay benefit from a third party occupational health service. This was in place to promote staff health, support and wellbeing.

Requires improvement

Surgery

Public and staff engagement

- The hospital's web site provided some information about treatment and payment options. Further information required contact with the hospital for discussion. In the hospital waiting room a TV provided further details of treatments and procedures.
- The general manager told us they collected information from surveys and utilised the feedback to develop action plans and improvements that were required. Surveys included patient satisfaction, friends and family test, direct patient feedback and insurance provider feedback.
- Patient feedback was sought using the NHS friends and family test and an external patient satisfaction survey, from this information this survey 'Hot Alerts' were produced covering both positive and negative feedback from patients This was sent to the general manager and matron each Friday for prompt attention/distribution/ action of feedback. We reviewed the externally survey results from the July 2016 survey; the data did not include how many surveys had been received. The results created an action log which included making the ambulatory area pods have a male and female end to ensure patients were comfortable in the glassed 'pods'. Other areas for action were, informing staff about noise at night and a focus on improvement and raising staff awareness about washing their hands.
- We saw no evidence of a patient forum or ways the service was trying to engage patients to provide insight and feedback
- The general manager was leading a staff forum which discussed new business and further developments. We reviewed the last presentation to the staff; there were no minutes to record any discussion or actions taken from the forum. The provider advised these were informal presentations for the dissemination of general hospital up to date information to staff who chose to attend. They were not a minuted activity encouraging all to speak freely. Any suggestions were taken on board by the person presenting and taken forward as appropriate.
- Staff felt included at a local level but not always included in decisions made corporately which affected them. The recent theatre development had required the support of all staff to continue working during the build, but no staff input had been considered into the design and detail.
- A whistle blowing policy was in place, last reviewed September 2015. This policy was accessible to staff should they wish to raise any concerns

Innovation, improvement and sustainability

- The hospital's web site provided some information about treatment and payment options. Further information required contact with the hospital for discussion. In the hospital waiting room a TV provided further details of treatments and procedures.
- The general manager told us they collected information from surveys and utilised the feedback to develop action plans and improvements that were required. Surveys included patient satisfaction, friends and family test, direct patient feedback and insurance provider feedback.
- There had been a recent development to increase theatre capacity and space for ambulatory care admissions, this meant patients could have greater access to day surgery and treatments.
- There had not been successful recruitment when building the extra facilities to include staffing of the new theatre, no new staff were in place and agency and bank staff were being used.
- There was no increase in cleaning staff or equipment when the new ambulatory care area opened. No forward planning was noted to have been considered to meet the extra demand.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

Mount Stuart Hospital provides outpatient and diagnostic imaging services for both NHS, self-pay and medically insured adult patients. The hospital did not treat children and young people. The outpatient department provided the following services; orthopaedics (33%), general surgery (17%), gynaecology and obstetrics (12%), cosmetic surgery (10%), ear, nose and throat (7%), urology (6%), oral and maxilla ophthalmology (5%), gastroenterology (4%), dermatology (3%) and facial surgery (1%). Private health screening services were also available at Mount Stuart.

Diagnostic imaging facilities included an on-site x-ray and ultrasound. Plain film imaging on wards and fluoroscopy (study of moving body structures) in theatre was also performed. Ramsay UK Diagnostics provided a mobile magnetic resonance imagining (MRI) and computed tomography (CT) scanning service.

The hospital reported approximately 8,200 outpatient consultations per year, of which 20% were self-funded or medically insured patients and 80% were NHS patients. Patients attended consultant led outpatient clinics for initial consultations and follow-up appointments post operatively. Additionally, there were nurse led pre-admission assessments. In the outpatient department there were nine consulting rooms, two treatment rooms and one pre-assessment room. Clinics were held daily Monday to Friday between 7.30am and 8pm.

A cosmetic suite was separate to the outpatient department and provided consultations for cosmetic surgery and offered a range of non-surgical treatments; these non-surgical treatments were not inspected as part of this inspection. A private physiotherapy and sports injury service was available on site to include a gymnasium and treatment rooms.

During our inspection we visited the outpatient, diagnostic imaging, cosmetic suite and physiotherapy departments. We spoke with approximately 22 staff including the outpatient manager, aesthetic lead, radiology service manager, nurses, health care assistants, radiographers, consultants, resident medical officer, physiotherapists, physiotherapy assistants, radiographers, pharmacist, medical secretaries, receptionist, maintenance manager and housekeeping staff. We also met with the hospital's senior management team, to include the general manager, matron, operations manager and business administration manager. We met with five patients and observed care for six patients to include three consultations, two pre-assessments and one physiotherapy appointment. We looked at five patient records and reviewed data.

Requires improvement

Outpatients and diagnostic imaging

Summary of findings

Outpatient and diagnostic imaging services at Mount Stuart were rated as requires improvement overall.

We found:

- A high number of infection control risk areas throughout the outpatient department.
- In the absence of hazardous waste bins in consulting rooms, hazardous waste was not managed safely and had been placed within the household waste stream.
- There were not clear resuscitation procedures in response to a medical emergency. Staff confusion was apparent with locating the resuscitation grab bag or ward resuscitation trolley and resuscitation scenarios were not practiced in each department.
- Medicines were not always stored within the manufacturers recommended temperature range.
- There was no eligibility criteria for private patients, therefore consultants did not have clear guidelines for selection of patients which could be safely treated at the hospital.
- A fire drill had not been completed in over one year and in this time changes had been made to the building.
- The cosmetic surgery two stage consent process, with a two week cooling off period between the two stages, was not regularly practiced. Patients provided written consent at the time of admission for surgery. Furthermore, when a patient changed their treatment a new two week cooling off period was not always initiated.
- We were not provided with assurance that consultants using their own cameras for photography were abiding by the hospital's policy for storing and handling patient photographs securely.
- There was a lack of assurance cosmetic surgery patients were being considered and referred for psychological review when it was needed.
- There were a large number of gaps with the previous year's staff appraisals and therefore some staff had not received an appraisal for two years.
- There was not an effective governance framework or strategy to support delivery and good quality care.
- There was poor management of risks. Departmental risk registers were not evidenced to allow risks to be managed at a local level.
- Hospital wide clinical and internal audit arrangements were inconsistent in their regularity and accuracy. There was no audit at departmental level to allow individual actions to be identified.

However:

- Safe practice was observed and evidenced in the diagnostic imaging department and practice was in line with regulations.
- Staff were aware of their responsibilities to report incidents and safeguarding.
- Staffing levels ensured patients received safe care and treatment.
- Multidisciplinary team working was evident and staff respected each other's practice.
- All staff were observed to provide good care to patients which was friendly and compassionate. Patients were kept involved and informed and included in the decision making process. Staff ensured patients understood their care and treatment.
- The outpatient and diagnostic imaging service was organised to meet people's needs.
- The outpatient department identified areas of innovation and improvement to develop the service and the demands of the local population.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

Overall, we have rated the safety of the outpatient and diagnostic imaging service as requires improvement because:

- Infection control was identified as a risk area. Some staff's infection control practice was not in line with best practice. There was no risk assessment or inclusion on the risk register for the use of carpeted areas which posed a higher infection risk. Non-compliant sinks containing plugs and overflows were in use in both the outpatient and physiotherapy departments. The layout of the outpatient department posed an infection control risk with access to the sluice only via clean rooms and staff were eating and drinking in this clinical area. Nasopharyngeal endoscopes were not leak tested between each patient use, it is a cross infection risk if leaks are not identified. The infection control audits were not comprehensive or identifiable by department, the environmental audit showed areas were compliant when they were observed as non-compliant during the inspection.
- We found expired sterilised equipment , this showed poor stock rotation and checking processes.
- At the time of inspection clinical waste bins were not present in consulting rooms and we observed hazardous waste in the household waste stream.
- Risk assessments or the mitigation of risk for resuscitation were not in place. There was not an agreed and published local resuscitation procedure. There was confusion amongst staff in the outpatients department as to the location and the use of the resuscitation grab bag, this posed a risk that a response to a medical emergency would be delayed. There was no evidence of resuscitation scenarios being practiced in the departments to ensure staff were well prepared should they need to respond.
- The hospital did not have a documented exclusion or eligibility criteria for accepting private patients for treatment in the hospital. There was a risk consultants could select patients who were not safe to treat at the hospital.
- Medicines were not always stored within the manufacturer recommended range and room temperatures were not monitored for medicines stored in locked consulting rooms. This may place the medicines at risk of unsafe use.
- A fire drill had not been practiced for over one year and in this time changes had been made to the building.

However:

- There was a culture of incident reporting and staff could demonstrate lessons learnt from incidents reported.
- The diagnostic imaging department was observed to have good and safe practice in line with regulations.
- Medicines in the outpatient and diagnostic imaging department were stored securely.
- Records were stored securely to ensure patient confidentiality.
- Patient clinical records were accurate, complete and up to date.
- Staff were aware of their responsibilities and knew how to recognise and report a safeguarding concern.
- We were informed mandatory training was up to date.
- Nursing and medical staffing levels in the outpatient and diagnostic imaging service was appropriate to meet the needs of patients.

Incidents

- In the reporting period April 2015 to March 2016, 23 clinical incidents and five non-clinical incidents were reported in outpatients and diagnostic imaging. This was 32% and 10% respectively of incidents which occurred in the hospital between this period and lower when compared to other independent acute providers.
- Staff understood their responsibilities to raise concerns and record safety incidents and near misses. Incidents were reported on the internal electronic system which staff were confident in using. Staff told us they or their

colleagues received feedback following reporting an incident. Staff told us about changes made within the hospital or departments as a result of lessons learnt from incidents.

- A corporate incident policy was available to staff which outlined the approach to incident reporting and the responsibilities of staff to report and investigate incidents. Incidents were reviewed by the matron and delegated to the appropriate head of department for investigation.
- There had been no requirement for mortality and morbidity reviews. In the event of a death a review would take place at both the clinical governance and medical advisory committee to allow lessons to be learnt.
- There was clear information in place for reporting radiation incidents. Incidents relating to diagnostic imaging were discussed at local governance meetings and at the radiation protection committee, which met once a year. This committee was attended by the radiology service manager, the radiology governance lead and the head of corporate diagnostics. In the diagnostic imaging department staff told us feedback following incident investigations and lessons learnt were distributed three monthly, urgent lessons learnt were circulated as required.
- There had been no recorded incidents requiring external reporting within radiology between April 2015 and March 2016. Providers were required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R. Diagnostic imaging services had procedures to report incidents to the correct organisations, including CQC.

Duty of Candour

- Staff spoken with demonstrated an understanding of the duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the provider to be open and transparent with a patient when things go wrong in relation to their care and the patient suffered harm or could suffer harm which falls into defined thresholds. Staff could tell us the requirement to be open and honest with patients and provide an apology should something go wrong. Examples were provided of when this had been applied. We did not review any incidents for the outpatients and diagnostic imaging department that would require the duty of candour.
- The corporate incident policy did not include the requirement for the duty of candour. There was a separate being open policy which stated the requirement for the duty of candour to be within 10 working days of an incident being reported.

Cleanliness, infection control and hygiene

- The departments appeared visibly clean, with the exception of a few dusty areas in high or low touch areas of consulting rooms, for example above curtain rails. The housekeeping staff were responsible for cleaning departments and nursing staff were responsible for ensuring the cleanliness of consulting rooms. We saw evidence of department cleaning schedules and checklists.
- Between April 2015 and March 2016 there were no incidences of hospital acquired infections, including Methicillin Resistance Staphylococcus Aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA), Clostridium Difficile and Escherichia coli. Any infections were logged as incidents on the electronic reporting system. Patients were screened for MRSA at pre-assessment in line with corporate policy. There had been a recent change whereby the hospital no longer screened all patients and only screened orthopaedic patients or anyone who had contact with MRSA. The hospital intended to review this practice because although in line with corporate policy there had been examples of patients who had MRSA but would not have been subject to a screening and therefore would have been missed.
- Patients with a known or suspected infection could be isolated within the department by use of available consulting rooms.
- We observed some good infection control practice amongst different staff groups to include; the use of hand gel, compliance with the five moments of hand washing between patients and use of personal protective equipment, which was readily available. However, we also observed activity which was not in line with best practice. One consultant was not bare below the elbow and had a wrist watch on while delivering

patient care. No hand hygiene practice was observed by a consultant during a consultation. One healthcare assistant prepared a couch between patients following an orthopaedic examination and did not clean the couch before replacing fresh linen, there was also no hand washing or use of hand gel. Dirty linen was observed being carried, not bagged, through the reception waiting area to the linen storage area. These issues did not promote good infection control practice.

- Reception staff encouraged patients to use the alcohol hand gel available on reception. Patients were also encouraged to wash their hands in the disabled and male toilets, however hand washing posters were not displayed in the ladies' toilet.
- Clinical wash hand basins were not compliant in two rooms as they contained plugs and an overflow which posed an infection control risk. These rooms were previously used as inpatient bedrooms and had not been reviewed in line with their new role. In the physiotherapy department clinical wash hand basins also included a plug which was not compliant. Paper towels were appropriately located next to clinical wash hand basins to dry hands efficiently and hand washing posters accompanied the majority of clinical wash hand basins to promote good practice for hand washing.
- The two treatment rooms had compliant vinyl flooring. Six out of nine consulting rooms and the pre-assessment room were carpeted, one consulting room which was previously used as a bedroom had a stained carpet. Carpets pose a higher infection risk as they were not so easily cleaned. The Department of Health best practice guidance, health building note 00-10 part A flooring, states if carpets are present for non-clinical areas, to include consulting rooms, a local risk assessment should be completed and a clearly defined pre-planned preventative maintenance and cleaning programme should be put in place. The use of carpet was not supported by a risk assessment or included on the hospital's risk register. The outpatient manager informed us the plans for one consulting room commonly used for pre-assessment and the pre-assessment room to be changed from carpet to compliant flooring. The Ramsay Health Care Director of Clinical services provided a statement which included that there was an on-going refurbishment programme. Staff told us in the event of bodily fluid spillages a spillage kit would be used, followed by a steam cleaning. At the time of inspection the housekeeping staff did not have access to a steam cleaner for 11 days while waiting for a replacement and in this time would not have been able to clean carpets in line with requirements. New filters were on order for the vacuum cleaners to improve infection control.
- Children toys in the waiting room were not cleaned routinely or recorded as cleaned, they were cleaned as part of the general cleaning for the outpatients department.
- There was a risk of cross infection with staff eating and drinking in a clinical area. Between the two treatment rooms was an adjoining room which was used by staff to makes hot drinks, there was a food waste bin which contained a banana skin and we were told staff biscuits and cakes were placed in this room. Within this room there was clinical equipment for monitoring, ophthalmic scopes, syringes, pots and a sharps bin which had contaminated sharps. Clean linen was stored on a shelf which posed a risk of dust contamination. We also found perfume and shoe polish within one cupboard.
- Nasopharyngeal endoscopes were not leak tested after each use which was required in line with guidance for decontamination, HTM01/06 part E testing. The department used a three-part decontamination system to decontaminate the equipment between patients. It was confirmed staff wore apron and gloves as personal protective equipment while using the decontamination system, staff should have goggles available to be used. Endoscopes were taken to the sluice to be decontaminated, the entry to the sluice was through a clean storage area for equipment and therefore there was a risk the clean storage area could become contaminated by dirty equipment. At the time of the unannounced inspection a new leak tester was available and staff were awaiting training. The outpatient manager informed us more endoscopes were being ordered so there would be eight available in the department compared to the previous two. This would allow the scopes to be sent to the on-site theatre sterile services unit for decontamination following use and so remove the need for the decontamination system.

Requires improvement

Outpatients and diagnostic imaging

- The ultrasound department had a cleaning procedure for intra-cavity probes, all probes were cleaned with the appropriate decontamination system wipes.
- The maintenance manager had processes in place for water management and we saw evidence of the action plan. Housekeeping staff were responsible for flushing all taps. Legionella water testing was completed monthly. An action plan, reviewed weekly, was in place if water temperatures were high and if bacteria count raised.
- The hospital's committee structure included the infection control committee, there had been gaps in the committee meeting at the time of the new matron coming in to post. The matron was the infection prevention control lead. There was a lack of knowledge of infection control practice within the hospital and any actions following audits or infection risks should have been be placed on the hospital's risk register to enable local monitoring and management. Going forward the new matron as the infection prevention control lead, said they wanted to promote infection control throughout the hospital and would aim to introduce an infection control link nurse within each department.
- Corporate infection control policies were available to staff and staff were aware of how to locate these.
- Infection control audits to include hand hygiene audits and environmental audits were completed hospital wide, this did not allow issues and specific actions to be identified at a departmental level. Therefore, departmental managers were not aware of their own infection control audit actions. With exception the diagnostic imaging department completed and recorded separate audits, we saw 86% compliance in January 2016 for environment and 100% compliance in April 2016 for hand hygiene. Observational hand hygiene audits hospital wide were completed quarterly. In April 2016 100% compliance was achieved, however this was only based on three staff members which is a poor representation of staff hand hygiene throughout the hospital. The hospital wide infection prevention and control environmental audit achieved 97% in May 2016, actions were recorded for areas of non-compliance. Within the hospital's infection control environmental audit, some standards were marked as compliant however, we found them not to be compliant at the time of the inspection. For example the audit evidenced hand wash basins were free from plugs and overflows, we found wash hand basins with plugs and overflows in both the outpatient and the physiotherapy departments. This suggests the auditing completed was not accurate. The provider informed us after the inspection that this audit only takes a sample of sinks across the hospital, however this was not documented on the audit.

Environment and equipment

- The arrangements for managing waste did not keep people safe. Hazardous waste bins were not present in consulting rooms. We observed inappropriate waste streaming of hazardous waste in to the household waste stream, we identified gloves placed in the paper towel waste bin and there was a potential that other hazardous waste may be in the same bin. At the time of the unannounced inspection consulting rooms had been supplied with a suitable bin with a lid and pedal, containing an orange hazardous waste bag. The ears, nose and throat consulting room still contained a pull out bin with no lid, this posed a risk of cross infection.
- Sharps bins were labelled and held securely, they were temporarily closed when not in use.
- There were good processes in place for handling clinical specimens, specimens were stored appropriately while awaiting collection from the courier.
- Staff informed us equipment available was appropriate for them to provide care and treatment to patients. The equipment was compliant with the Medicines and Healthcare products Regulatory Agency. The maintenance manager oversaw equipment and staff said any repairs were done in a timely manner. Staff received training when new equipment was introduced in a department to ensure they were operating them safely.
- Electrical appliance testing was completed by the maintenance manager on a rolling programme. We did identify some equipment where dates had expired, rubbed off or where old dates had not been removed. We were therefore not provided with assurance these had been checked within the appropriate timescales to confirm equipment was safe to use.
- Personal protective equipment was readily available in the departments. We observed organised stock rooms

and on a random check equipment was in date. We found packaged sterile equipment in one consulting room which had expired, This included a probe which expired over one year prior to the inspection in August 2015 and a forcep which expired the week prior to our inspection. Staff completed a daily checklist which included a check that sterile instruments were in date. We observed in the drawers stock rotation could be improved because longer dated items were found at the top of the drawer.

- Fire exits were displayed and fire routes were not obstructed. We observed in the area outside consulting room four and five there were no signs to direct patients to evacuate the building. Fire extinguishers were readily available and within their check date.
- Lasers were used in the cosmetic department, and national and local policies were followed. The laser protection advisor contact details were held in the department. All staff using the laser were trained online and undertook regular updates to ensure their safe practice.
- There was a security risk when we found keys left unattended. We were given access to one locked consulting room, within this room we found two bunches of keys, one was labelled for the lower ground, the second bunch were not identifiable by us or staff during the inspection.
- The physiotherapy department stored crutches and walking frames available for patients.
- Bariatric scales were available, all other equipment was assessed as appropriate for bariatric patients.
- One hoist was available in the hospital, this did not take patients with a body mass index of over 40. We were told some self-funded or medically insured patients may be seen in the hospital with a BMI exceeding 40. There would not be an available hoist to safely move these patients.
- The diagnostic imaging department had a quality assurance programme in place. Following on from the most recent radiation protection report the radiation protection advisor had pointed out a lack of radiographer led audit. This was due in part to a lack of locally available testing equipment, this has now been purchased and we saw evidence that quality assurance was regularly carried out and additional staff were being trained to undertake radiographer quality assurance.
- X-ray equipment had regular servicing carried out by manufacturer engineers. We saw evidence of the manufacturer's completed service reports. We also saw evidence of routine surveys of all X-ray equipment, this was carried out by the medical physics service which was an outsourced arrangement via a service level agreement reviewed annually. We saw evidence of these surveys.
- There was no capital rolling replacement programme, but individual bids for new equipment were led by the radiology service manager. There was currently a bid for new direct radiography equipment in the general x-ray. Some of the imaging equipment was near end of life, but close links with the radiation protection advisor and manufacturers ensured x-ray equipment was not unsafe, by ensuring the equipment was subject to regular servicing, quality assurance and dose audit. Medical physics and radiology worked together to form part of the procurement process.
- In diagnostic imaging all personal protection equipment was available, clean, stored appropriately and subject to annual checks. There were good contingency arrangements for equipment breakdown, the corporate provider had a contract with a medical equipment service which had a service level agreement for next day response by an engineer.

Medicines

- Medicines were stored in locked cupboards and medicines fridges. Some frequently used medicines were kept in the ears, nose and throat and eye clinic rooms, these were not stored in locked cupboards, although the rooms were locked when empty. Room temperature was not recorded in these clinic rooms. Where temperature was recorded, records showed medicines were not always stored within the manufacturer recommended range. Although staff could sometimes explain what action should be taken when temperatures appear to be out of range, it was not possible to check these actions had been followed.
- Pads of prescription stationary were stored securely and their use logged. There were a large number of pads

kept in store with four spare pads and there was no process to check whether any prescription sheets had gone missing. The resident medical officer dispensed medicines required for people to take home from stock. A second staff member checked for accuracy.

- The radiology department kept a supply of relevant and appropriate medicines for the procedures carried out. These were stored securely but the records showed the maximum temperature had been recorded above the manufacturers recommended temperature since 18 July 2016. Staff did not know how to reset the thermometer or what action to take when temperatures went out of range. This posed a risk medicines were not stored under conditions which ensured their quality was maintained.
- The hospital pharmacist had been in post for six months, since in post prescribing and medicines management audits had been completed hospital wide. The May 2016 prescribing audit showed 76% compliance and the April 2016 medicines management audit showed 64% compliance. Gaps in the outpatients department included in one out of three prescriptions there were no allergies or sensitivities documented and there was no local policy in place in the department for ordering medicines. The pharmacist had plans to work with the matron to develop an action plan regarding the areas where improvements needed to be made.
- During pre-admission assessment the nurse discussed the patient's current medication and confirmed the medication they should have available with them on the day of surgery.
- Prescription records and anaesthetic charts were prepared in outpatients and the nursing staff were responsible for recording patient allergies. On review of four patient records allergies were correctly recorded in three cases. In one case there was nothing recorded, so there was no confirmation the patient had no known allergies.
- During the daily hospital briefing it was raised how glucagon (a medicine used within the hospital) had been re-called. This was actioned immediately and returned.

Records

- Patient clinical records seen were accurate, complete and up to date. We found consultant records at times were difficult to read if they were hand written.
- Prior to outpatient clinics the patient clinical records were held securely in the department. Patient clinical records were stored onsite, and for three months following patient discharge. They were then archived to a secure approved off-site storage facility and scanned on to Ramsay's electronic system. Medical records were rarely taken off site. A confidentiality clause was signed by all staff and if a consultant wished to take notes off site they would be referred to the corporate policy covering the security of medical records outside a Ramsay healthcare facility.
- Records for outreach clinics were secured in a box with a combination lock. We were told records would be returned immediately to the hospital following the clinic.
- Secure email portals were used when sending patient identifiable information. ISO 27001 accreditation was held which demonstrates best practice for information security.
- Record audits were completed on the ward which picked up elements of the outpatient department record keeping. Compliance with the audit was at 82% in January 2016 and 76% in April 2016. Actions were shared with the ward staff only, and therefore there were no actions or lessons learnt for the completion of records in the outpatient department.
- Record keeping audits were completed in the physiotherapy department, the last audit completed in November 2015 was 89% compliant.
- A radiology information system (RIS) and picture archiving and communication system (PACS) was used in the diagnostic imaging department. This meant patients radiological images and records were stored securely and access was password protected. The RIS and PACS systems interfaced well with one another and there was rapid access to stored data. There was good access to the local NHS hospital PACS system and image transfer from Mount Stuart was via the image exchange portal. A review of 10 patient records demonstrated all necessary information including scanned documents and safety checklists were stored correctly.

Requires improvement

Outpatients and diagnostic imaging

Safeguarding

- The hospital matron was the safeguarding lead and attended a local safeguarding forum, forming safeguarding links within the local area. Updated level three training was planned for the new matron. In the interim the previous matron was available to contact, should advice be needed. The safeguarding lead for Ramsay Health Care was contactable in working hours and out of hours staff would contact the local authority safeguarding lead for advice.
- The corporate safeguarding adults at risk of abuse or neglect policy and children and young people policy was available for staff. This included information on prevent and female genital mutilation.
- Departments displayed the safeguarding contact numbers so these were easily available for staff. Staff were aware of their responsibilities to report safeguarding and the processes they should follow. The aesthetic head of department clearly explained a safeguarding referral that had been made by the hospital when concerns had been raised by staff in her department which demonstrated clear understanding of the safeguarding process.
- We were told staff completed adult and children safeguarding training. Compliance for training was not reported. Nursing staff told us they were trained at level two and all radiology staff had undertaken level three safeguarding training.
- Female genital mutilation was included within the safeguarding training. Staff spoken with were aware of female genital mutilation through their training.

Mandatory training

- Staff spoken with were happy with the quality of training they received which was a combination of e-learning and face to face. Staff said their training was either complete and up to date or they were in the process of completing. The departmental managers were responsible for booking staff on to the required training sessions and this information was displayed on the staff noticeboard. We were told booking was planned one year ahead for all mandatory training to ensure training was scheduled effectively.
- Staff spoke about the hospital induction day for new staff which ran regularly and included some mandatory training modules to provide new staff with the training they required.
- At the time of the inspection the current system did not allow the hospital to run an automated report, a manual record was being maintained. From this record mandatory training compliance was reported for completed or booked training as 100% for outpatients department, 100% for diagnostic imaging department and 96% for the physiotherapy department.

Assessing and responding to patient risk

- There was no eligibility or exclusion criteria for treating private patients. For NHS patients the exclusion criteria was sent to the referral support service so choose and book patients were selected as appropriate. Staff said private patients were excluded on a case by case basis, dependent on the patient and the treatment they would receive. However, we were told by staff how some private patients were selected for bariatric treatment when they were above the body mass index of the NHS exclusion criteria.
- Patients completed a medical questionnaire before their first appointment in outpatients to allow any risk areas to be identified.
- All patients allocated for surgery underwent a pre-assessment by nursing staff. Pre-assessment one was completed for all patients following their consultation. Orthopaedic, cosmetic and major gynaecology patients and any patients identified as a concern were booked an appointment two weeks before their surgery for pre-assessment two.
- Risk assessments were completed as part of the patient's pre-assessment to allow for risks to be managed positively. Risk assessments include venous thromboembolism, malnutrition universal screening tool, manual handling, Waterlow (pressure ulcer risk assessment) and the risk of falls.
- We observed two pre-assessments and can confirm appropriate questions were asked to the patient to identify risk areas and ensure the patients were safe for surgery and following their surgery.
- In the event of a medical emergency, staff were aware of their responsibilities to call 999 which was the pathway

followed for escalation to the NHS, staff would respond as they saw appropriate while they awaited the assistance of the 999 response. One staff member in outpatients provided an example of how they would deal with a medical emergency. The resident medical officer would complete a referral form and the patient clinical notes would be photocopied. The service level agreement for the transfer of patients was not agreed as updated and was last reviewed in March 2010.

- Resuscitation equipment was not available in the outpatient or diagnostic imaging department. Staff would retrieve the resuscitation trolley from the ward. The physiotherapy and cosmetic suite had access to a resuscitation trolley. Both resuscitation trolleys were checked daily and resuscitation equipment was readily available. In the physiotherapy department we observed a single use resuscitation bag attached to the oxygen cylinder. There was no date of this bag being placed in service and no checking system. The bag looked worn and was not completely sealed so there was a risk of contamination. Physiotherapy staff informed us the single use resuscitation bag would not be used and their first point of call would be the resuscitation trolley. This poses a risk of confusion in the event of a medical emergency. The mobile diagnostic imaging service provided their own resuscitation grab bag to allow them to respond to an emergency.
- The arrangements for resuscitation were a risk area within the outpatient and diagnostic imaging service. There was no evidence of risk assessments or mitigation of risk. Within the outpatients department there was confusion with the use of a new grab bag containing resuscitation equipment and where it was located which posed a risk that staff would not respond correctly in an emergency. We were first told the grab bag was locked in the outpatient manager's office and staff would need to obtain the key at reception to enter the office and retrieve the grab bag. Two staff members told us they would locate the grab bag in the corridor room between the treatment rooms, the grab bag was not located here at the time of the inspection. One staff member told us they were not using the grab bag because they were waiting for training. One staff member said the resuscitation officer said the grab bag would confuse staff and therefore they should continue to use the ward resuscitation trolley. These findings were fed back to hospital management during the inspection and the hospital then confirmed the grab bag would not be used until staff had received training and staff were informed during the course of the inspection to use the ward resuscitation trolley.
- The resident medical officer was trained in advanced life support. Staff in outpatients and radiology were compliant with basic life support and immediate life support.
- Resuscitation scenarios were not evidenced as completed. Staff told us scenarios had been completed on the ward and with the mobile diagnostic imaging unit. We were not provided with assurances the outpatient, diagnostic imaging, physiotherapy and cosmetic departments had been involved in resuscitation scenarios and could access the relevant resuscitation equipment in a timely basis. The hospital submitted to us that there was no mandatory requirement for departmental scenarios so these had not taken place. This was not compliant with the Ramsay Healthcare policy which states scenarios must be held bi-monthly and in different areas of the hospital, to include full arrest scenarios and other emergency situations. We were told the hospital were looking at introducing scenarios via trained hospital staff.
- There was no local resuscitation procedure to identify the location of the resuscitation equipment within the hospital and the resuscitation team and their responsibilities, this was not compliant with the Ramsay Healthcare policy. A draft procedure document had recently been prepared and was under review.
- A new critical care team had been formed and going forward planned to hold committee meetings to ensure the processes for response to resuscitation were monitored and in line with safe practice.
- The resuscitation team was manned by four staff during daytime hours and two staff out of hours. In daytime hours this included the RMO and the nurse in charge, the anaesthetist and ODP in theatre. Out of hours this was the RMO and nurse in charge.
- Resuscitation bleep holders included; the resident medical officer, ward nurse in charge, anaesthetist and the operating department practitioner during the day. Out of hours the resident medical officer and ward nurse in charge were bleep holders. There was no resuscitation bleep holder in the outpatients

department, staff in the department would respond via the nurse call bell system which linked with an emergency call. Resuscitation bleeps were tested weekly, there was a risk in between those days the bleeps will not be working. This is not compliant with Ramsay Healthcare policy which states the registered manager is responsible for ensuring there is an emergency system in place that works and is tested daily. Staff said there was no concern as a number of staff respond to an emergency call, however this has a risk, without a clearly allocated resuscitation team there will be too many staff members involved which may be detrimental to coordinating the appropriate response for the patient.

- All diagnostic imaging procedures were reviewed annually and ratified by the head of diagnostics and the radiation protection service. Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) procedures were in place and all documentation was available in paper format but was also available to staff electronically. All radiology staff spoken with were aware of how to access the information.
- The radiation protection service which was provided by an outsourced company led the radiation protection service at Mount Stuart. They provided the radiation protection advisor and medical physics expert for diagnostic imaging. The service level agreement was routinely reviewed and there were no perceived changes.
- There was a radiation protection supervisor for the hospital who was trained through the radiation protection service. Their role met with the Ionising Radiation Regulations.
- We saw evidence radiographers, with advice from the radiation protection advisor, carried out risk assessments for all new equipment or procedures.
- There was a programme of dose audit in place in order to review patient doses and reference levels as required by IR(ME)R, these were set with some locally derived data to better reflect local practice and equipment.
- The world health organisation checklist for interventional radiology was in place for joint injections undertaken in the fluoroscopy room and compliance with this was 100%.
- The diagnostic imaging department adhered to a corporate policy for the escalation around urgent and unexpected findings.

Nursing and other staffing

- Staffing levels were as planned. We were informed the electronic rostering system ensured safe staffing levels in line with Royal College of Nursing and National Institute for Health and Care Excellence (NICE) guidance of safe staffing. The number and the type of clinics determined the staffing, staffing was reviewed regularly by the outpatient manager. Some staff members had specific skills and this was managed on a case by case basis. When visiting the departments staffing levels were appropriate to meet the needs of patients. Staff spoken with said staffing levels were always appropriate to provide people with care and treatment.
- The outpatient department had 5.6 full time equivalent (FTE) nursing staff and 4.7 FTE health care assistants. Diagnostic imaging had two permanent radiographers.
- Agency staff were not used as a contingency workforce, however regular bank staff were used in both the outpatient and diagnostic imaging departments when regular staff were not available.
- Physiotherapy staff had been working short of their full staff compliment since 2015. Recent recruitment and change of leadership have meant improvements for the physiotherapy team.

Medical staffing

- There were 103 consultants with practising privileges. Clinics were run dependent on consultant availability and therefore medical staffing was a reflection of activity. There were six radiologists who were based at the local acute NHS trust who provided cover.
- The resident medical officer was provided by an outsourced agency. One resident medical officer was available on site 24 hours a day for the period of their rotation, this was usually one or two weeks. The resident medical officer was available to support the outpatient department, for example one responsibility of the resident medical officer was to review patient electrocardiograms, if anomalies were identified they would raise this with an anaesthetist to review.

Major incident awareness and training

Requires improvement

Outpatients and diagnostic imaging

- The arrangements in place to respond to emergencies and major incidents were included in the hospital's business continuity plan.
- The outpatient manager could demonstrate different ways they would respond to potential risks for example impact of adverse weather or disruption to staffing.
- The hospital has an emergency generator which provides back up for 30 hours. The maintenance manager checked the generator weekly with monthly testing, we reviewed evidence of these tests being completed.
- We saw evidence of the local fire policy which was currently being reviewed. A fire test was completed weekly. A fire drill with evacuation had not been completed for over one year, the last drill was in August 2015. This meant since the build and change in hospital layout, which finished in April 2016, there had been no drill, a drill was planned in the weeks following the inspection. We were informed a fire inspection had been completed and the hospital were awaiting the final report.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

The effectiveness of the outpatients and diagnostic imaging service was not rated due to insufficient data being available to rate these departments nationally.

We found:

- The departments had knowledge of best practice guidelines and applied this to their working practice.
- Multidisciplinary team working was evident with staff of different roles and from different departments working together to deliver effective patient care and treatment.
- All information needed to deliver care and treatment was available in a timely manner.
- Information about outcomes of patient care and treatment was not routinely collected and monitored.
- Written consent for cosmetic surgery patients did not follow a two staged consent process, with at least a two weeks cooling off period between each stage. Patients were regularly formally consented on the day of admission to surgery.
- The two week cooling off period was not achieved for cosmetic patients when the patient requested a last minute change to their cosmetic procedure.
- There was no assurance to confirm photographs for cosmetic surgery taken by consultants using their own cameras were held and handled securely.
- There were gaps in the previous year's appraisals being completed, which meant staff were not provided with an opportunity to regularly discuss their work, competencies, developments and personal goals.

Evidence-based care and treatment

- Policies and guidelines had been developed in line with national guidance and were available to staff electronically. Care pathways were evidence based and related to the most recent guidance. National Institute for Health and Care Excellence (NICE) guidelines were sent to each head of department and consultants on a quarterly basis. Staff said the anaesthetists regularly kept them informed of any changes to guidelines and if there were changes in the local acute trust the consultants would inform the hospital.
- The was an effective system in place for the distribution of alerts from the central alert system. We saw evidence of a central alert system log for July 2016.
- Template documents were used in the outpatient department, examples include pre-assessment document, cataract care pathway, surgical day case pathway and hip replacement care pathway.
- In the outpatient department there was little evidence of auditing practice against the guidelines. A pre-admission and discharge planning audit was completed every six months, in January 2016 compliance was at 97% checking ten patient notes. The audit aimed to confirm relevant documentation was completed and in accordance with NICE guidance.
- The provider had a radiation safety policy. The head of radiology signed off all new documentation and revised procedures.

Requires improvement

Outpatients and diagnostic imaging

- Clinical staff had a sound knowledge of Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R relevant to their area.
- Local diagnostic reference levels (DRLs) had been established for some examinations and were routinely reviewed by the medical physics service with on-going dose audit work to increase the amount of locally derived data.
- Referrers and radiographers could access an electronic referral a guidance tool written by the Royal College of Radiologists.
- Exposure charts, to provide consistent results, reduce number of exposures and allow direct comparisons of films being taken at different dates, were available in the x-ray rooms visited. Exposure parameters were pre-programmed on the equipment.
- The radiology service manager told us they meet with other hospitals within the provider group, this allowed them to benchmark their service discussing what they do and standardising policy and procedure and sharing practice. They also had regular meetings with regional heads.
- The diagnostic imaging department had adopted the Society and College of Radiographers pause and check safety procedure.
- A radiology request card audit was carried out as part of the audit programme to ascertain compliance with the employer's procedures and referral criteria. This was evidenced at the time of the inspection with 100% compliance. There was a regular audit of non-medical referrers requests which also demonstrated 100% compliance. All radiologists were subject to a reporting discrepancy audit as required by the Royal College of Radiologists. Reject analysis of sub-standard images was good, with audit results at less than 5%
- There was a regular audit of images that were acquired and did not receive an official radiology report. It was highlighted in one audit there was low compliance in surgery of the recording of medical exposures but it was stated all exposures were looked at during the course of the surgical procedure. Surgeons were reminded of the requirement to make a more formal comment about the images as required under IR(ME)R and local agreements. A follow up audit was not seen at the time of the inspection.

Pain relief

- Staff said they would be able to contact the pain management team at the local acute trust should they require support.
- One consultant ran private pain management clinics and patients could be referred to their service.
- When observing pre-assessments nursing staff made patients aware of the pain anticipated following surgery and encouraged them to ensure adequate pain relief was available at home following their discharge.

Nutrition and Hydration

- Patient nutritional and hydration needs were discussed as part of the pre-assessment. During an observation of a pre-assessment the nurse confirmed the patient's fasting instructions for surgery, however it was not discussed in detail what food or drink could be consumed. We did not observe nausea being discussed at this appointment.
- At pre-assessment the patient's weight and height were recorded to allow calculation of the body mass index and determination of a malnutrition universal screening tool (MUST) score. This tool allows patients who are malnourished, at risk of malnutrition or obese to be identified. The patient's MUST would subsequently be monitored from admission to discharge.
- Drinks were available in the department waiting areas, hot drinks were payable for NHS patients with the availability of a water fountain. Staff told us if patients were waiting for long periods of time in the department they would be offered a complimentary drink and arrangements could be made to provide patients with food, particularly if a patient was diabetic.

Patient outcomes

- Patient outcomes were not specifically monitored in the outpatient department. Outcomes were monitored in the outpatient follow-up appointment in line with surgical treatment received.

- There were no physiotherapy patient outcomes to measure changes in patient health and quality of life. We looked at the physiotherapy audits for partnership, record keeping and evaluation of care. We saw that they scored highly with some issues noted around consent and record keeping.

Competent staff

- A process was in place to flag pending registration and revalidation for staff registered with the general medical council, nursing and midwifery council or the health professions council. We were informed the electronic health roster system would not allow staff to be rostered for duty if their registration information was out of date.
- New staff across all departments undertook an induction process before completing specific competencies relevant to their role. A staff induction day was being run during the time of inspection. In the outpatient department we saw evidence of two competency books completed for a healthcare assistant and a registered nurse, and one competency book for a new healthcare assistant which was in progress.
- On an on-going basis staff should receive personal development reviews to set objectives and identify training needs, this forms the annual appraisal. Departmental managers confirmed all appraisals were complete, although gaps were evident in the past. We saw evidence of two completed appraisals for the outpatient manager and a health care assistant, both had received an appraisal in June 2016, however their last appraisal was June 2014, two years prior. All staff spoken with said they had received their appraisal, and although they did not have regular one to ones they were able to find support from their colleagues or manager.
- Staff said they received additional training to allow them to develop personally, there was a monthly drop in session opportunity for training to be completed. One healthcare assistant explained how they had received phlebotomy training (taking blood) so they were competent in pre-assessment clinics and one nurse had attended a bariatric study day to improve their skills and knowledge to work with bariatric patients.
- A buddy system was in place in the outpatient department. Each healthcare assistant was linked to a trained nurse. Additionally, all new staff were provided with a buddy and were made supernumerary until they were competent.
- The senior management team were assured the consultants were skilled, competent and experienced to perform in their hospital. The consultants working under practising privileges were asked to provide evidence of the work they carried out at local acute trusts or other independent healthcare providers. Consultant portfolios were shared with specialist advisors for Ramsay Healthcare to verify their practice. The medical advisory committee (MAC) were responsible for granting consultant practising privileges and reviewing their practice. On an on-going basis the employing local acute trust or the accountable officer provided evidence of the consultant's annual appraisal. There were arrangements with commissioners to review consultant practice, for example any trends with incidents or complaints associated with a consultant.
- The competency of the resident medical officer was monitored by the providing agency, the hospital review the CV of the resident medical officer to confirm their skills and experience.
- Continual professional development within the diagnostic imaging department was encouraged and regional meetings for shared learning were accessible. The radiology service manager was looking towards a cannulation and contrast administration course for radiographers.
- We saw evidence of a detailed equipment training programme for radiographers and radiologists. The lead radiographer signed off each operator once considered competent to use a piece of equipment. On-going competencies were assessed annually.

Multidisciplinary working

- All necessary staff were involved in assessing, planning and delivering people's care and treatment. We observed good multidisciplinary team working across staff roles and departments during our inspection. Staff said there was effective communication between each other and different departments within the hospital. For

example nursing staff in the outpatients department were able to contact the resident medical officer or the physiotherapy team should their patient require further support.

- In one appointment date and time patients were able to see the consultant, nursing staff for pre-assessment and radiology team for diagnostic imaging. This allowed the multidisciplinary team to work together to provide care and treatment to the patient.
- It was a requirement for bariatric patients to see the consultant, dietitian and psychologist, although this was not provided as a one stop clinic.
- Externally we were told the hospital communicated well with GPs. A GP liaison officer represented the hospital and we were told they were building strong links with the local GPs and practice managers. Relationships were also formed with the local acute trust to provide additional support, for example working with their diabetic team.
- The radiology service manager and their team had a working relationship with referrers and were able to challenge requests that may be unjustified. Radiographers told us there was always a radiologist available for advice relating to imaging requests and unusual or urgent findings. We were told there was a good link with the local NHS trust radiology department.

Seven-day services

- The outpatient department operated a five day outpatient service, Monday to Friday, 7.30am – 8pm. There were instances when Saturday clinics were also held.
- The physiotherapy department was open Monday to Friday and physiotherapists could be requested to support in the outpatients department if required. Physiotherapists were also available at weekends to work on the wards.
- Pharmacist support was available two days a week. Outside of these working days the Ramsay Healthcare group pharmacist or pharmacist from the sister hospital could be contacted for advice.
- The diagnostic imaging department was open Monday to Thursday with no weekend working. Radiology staff were employed on a flexible working contract in order to ensure all clinics and theatres were covered and staff were able to be flexible with hospital demands. An on-call rota was also managed to ensure emergency cover could be provided. There was access to a radiologist out of hours for urgent reporting either through the voluntary rota of the six NHS radiologists or 24 hours via an outsourced reporting company.

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. Patient clinical records were held on the hospital site and we were informed there were no reported incidents of relevant records not being available. A tracker system was used to locate patient clinical records. However, one staff member did comment how the use of the system could be improved, if colleagues did not use it correctly this caused difficulties in locating notes.
- Staff said diagnostic images were readily available on the electronic system, these were accessed through the picture archiving and communication system. For images acquired off-site, the image exchange portal and other local image gateways were utilised. Radiologists who were based off-site had instant access to images.
- Communication between the consultant and the GP were evident on the patient record. Consultants would write to GPs following initial consultation and follow-up appointments to ensure they were well informed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff spoken with demonstrated an understanding of consent and decision making requirements in line with legislation and guidance.
- Stage one of consent forms were completed in outpatients for patient's agreement to investigation or treatment. Consent stage one included recording the proposed procedure or treatment, intended benefits and significant, unavoidable or frequently occurring risks. Stage one was signed by both the consultant and the patient and should be initiated within a satisfactory period of time to allow the patient to make a decision to proceed, or to ask further questions, allowing them to

make an informed decision. The consent was then confirmed at stage two by a health care professional prior to anaesthesia or treatment, this was commonly completed at patient admission.

- For cosmetic surgery consent should be obtained in a two-stage process with cooling off period of at least two weeks between stages to allow patient to reflect on their decision. If not possible good reasons should be documented in the patient's notes. This is in line with the Royal College of Surgeons professional standards for cosmetic practice 2013. Common practice appeared for consent stage one and two to be signed on the day of surgery for cosmetic patients. This does not follow the two stage consent process as per national guidance and corporate policy.
- All staff spoken with were aware of the requirement for a two week cooling off period for cosmetic patients, medical secretaries abided by this rule when booking patients for surgery. Any changes to the procedure should re start a two week cooling off period. However, there were examples where an additional two week cooling off period was not honoured when patients changed their mind last minute. At the time of the inspection one patient was seen for a pre-assessment, the patient requested to try on the bras for size and was encouraged to do so and informed they could also do this on the day of their surgery to ensure they were certain of the sizing. There was no explanation of the two week cooling off period, should they change their mind, given to the patient at this time. The patient decided to change to a bigger implant and was booked in to see the consultant to confirm these changes, this appointment was only six days before planned surgery.
- On review of five cosmetic surgery records consent forms were complete in four cases including benefits and risks of surgery. One patient had completed consent stage one and was awaiting surgery, two patients had completed their surgery and stage one was complete at consultation and stage two on admission, and one patient had consent for investigation or treatment completed. For one patient undergoing cosmetic surgery there was a record to say consent will be completed on the day of surgery, this does not abide by the two stage consent process.
- Consent was obtained from patients in line with the clinical photography corporate policy. Medical secretaries informed us the consultants wrote to the patients and received written consent should they want to use the photographs for their website or other advertising purposes.
- Patient photographs in the cosmetic suite were stored and managed securely on the computer in line with corporate policy. There was no assurance to confirm the photographs taken by consultants on their own cameras were held securely and images were deleted from the device or memory card immediately after they had been printed or sent to the patient. This was not in line with the policy which states 'clinical images must ideally be taken using the hospital digital camera' and 'all images taken in Ramsay Healthcare regardless of who takes the image/s remain the property of Ramsay and copyright of the images is retained by Ramsay'.
- Completed National Joint Registry consent forms for orthopaedic surgery were requested to be brought to pre-assessment clinic.
- Consent audits were part of the audit programme and completed quarterly, in March 2016 10 records were reviewed and 100% compliance was achieved. This audit did not have specific reference to the two week cooling off period for cosmetic patients.
- Staff showed an understanding of the rights of people subject to the Mental Health Act and had regard to the MHA code of practice. We were told this forms part of the mandatory e-learning training. Patients would be referred to their GP for a mental capacity assessment if they were identified as lacking capacity. For patients over the age of 75 a dementia score was completed.
- Staff could explain the difference between lawful and unlawful restraint, however staff said they have never had the need to use restraint when treating patients at the hospital.

Are outpatients and diagnostic imaging services caring?

Good

Overall, we have rated caring of the outpatient and diagnostic service as good because:

Requires improvement

Outpatients and diagnostic imaging

- All staff were observed to provide compassionate care to patients, maintaining patient privacy and dignity and being respectful of their needs.
- Patient feedback about the care in the outpatient, diagnostic imaging and physiotherapy departments was consistently positive, evident through talking to patients and friends and family test responses.
- Staff communicated clearly with patients and ensured they understood their care and treatment.
- Patients were encouraged to be involved in the decision making process for their care and treatment.
- Staff recognised how they could provide emotional support for patients.

Compassionate care

- All staff were observed to be respectful of patients. Patient privacy and dignity was maintained throughout care and treatment. Staff introduced themselves to the patients and maintained a friendly demeanour. There was a patient focused approach throughout the departments.
- One patient spoken with commented how polite and helpful staff were in the outpatient department. Another patient said they had always had an excellent experience when visiting the department.
- One patient attending their physiotherapist appointment was happy with the care they had received. The physiotherapist and physiotherapist assistant had a good relationship with the patient, it was evident they knew the patient well and supported them through their exercises.
- One healthcare assistant provided high standards of patient care during a pre-assessment, the healthcare assistant had excellent communication skills with the patient and they maintained patient privacy and dignity throughout the assessment.
- We observed consultants who had a polite manner with patients and were respectful to their needs.
- Radiographers demonstrated compassion and care when speaking with patients. Privacy and dignity was maintained and all patients were identified and spoken to within the x-ray rooms away from public environments.
- The waiting area was close to reception and therefore there was a risk patients speaking to the receptionist were overheard. However, receptionists spoke to patients quietly to limit this risk.
- Staff in the diagnostic imaging department said they had time to spend with patients and assess their needs. This allowed for fewer pressures and less risk of errors during procedures and allowed patients to be examined in a calm and caring manner. Staff felt good care was delivered to all patients especially those with greater needs
- The hospital participated in the friends and family survey for NHS outpatients. In May 2016 there was a 1% response rate with 86% recommending, of 14 responses nine were extremely likely, three likely and two didn't know if they would recommend. In June 2016 there was a 3% response rate with 100% recommending, 30 patients said they were extremely likely and seven said they were likely to recommend. All comments for outpatients were positive, these included:
- 'Friendly and professional'
- 'Excellent care and treatment'
- 'Very pleasant staff and a relaxing environment'
- 'Excellent service and attention throughout'
- 'Prompt, friendly, easy to park, amazing staff who made me feel comfortable and at ease. Smiley receptionist answering all my queries.'
- 'Very relaxed, didn't feel rushed, was able to ask the questions I wanted and got direct answers'
- 'Really friendly efficient staff giving clear correct instructions.'
- 'All aspects of care were excellent'
- 'Incredible staff, very knowledgeable. Reception answered my queries without hesitation and the nurses knew all the answers to my silly questions. You put a very nervous patient at ease.'
- 'Quick and easy service. Great staff friendly clean environment.'
- Patients were supported when intimate personal care was being provided. We were informed the gynaecology, colorectal and breast surgery clinics always used a

chaperone. The availability of a chaperone was advertised to patients and displayed in the waiting areas and consulting rooms. We observed chaperones in use for gynaecology clinics and saw evidence of chaperone stamps in patient records.

Understanding and involvement of patients and those close to them

- We observed care being provided to six different patients, all staff communicated with patients clearly and concisely to ensure they understood their care, treatment and condition. Patients whose next appointment was their surgery were provided with detailed information as to what they should expect on the day of admission through to discharge. Patients and their relatives were provided the opportunity to ask questions and staff answered these in detail.
- During a pre-assessment we observed the nurse ensuring the patient understood how and when they would receive their test results. Patients spoken with said they were made aware of when test results would be available.
- Patients were provided with the hospital's contact number to allow them to contact the hospital if they had any worries or questions. Out of hours the phone call would be picked up by the ward.
- Following a consultation, self-pay or medically insured patients would be seen by the business office to allow for private discussions to inform the patient about the cost of their care or treatment.

Emotional support

- Patients were given support during their care and treatment. Treatment options were discussed and patients were encouraged to be part of the decision making process.
- Staff provided patients with leaflets and we observed staff talking the patient through the leaflet to reiterate important information.
- Staff spoken with could explain how they would provide emotional support to patients, for example putting an anxious patient at ease.
- We were told good communication with the GP allowed patients who needed additional emotional support to be identified.

Are outpatients and diagnostic imaging services responsive?

Good

Overall, we have rated the responsiveness of the outpatient and diagnostic imaging service as good because:

- The hospital was meeting the national indications for referrals for NHS patients.
- The choose and book system for NHS patients allowed patients flexibility in choosing their own appointment. For private patients medical secretaries aimed to arrange suitable and convenient appointments.
- The outpatient department would review demand and put on additional clinics to improve access for patients.
- The outpatient questionnaire allowed for patient individual needs to be identified to allow them to be accommodated throughout the patient pathway.
- Staff provided examples of how they would meet individual patient needs.
- Complaints were reviewed and investigated in line with policy. Complaints were shared at relevant committee meetings and lessons learnt disseminated.

However:

- Cosmetic patients were not routinely referred to a psychologist and there was a lack of assurance patients were reviewed for this referral.

Service planning and delivery to meet the needs of local people

- The clinics in the outpatient department were held dependent on patient demand and consultant availability.
- Consideration was given to services which were required for the local people. For example allergy testing was introduced in the hospital due to an 18 month wait at the local NHS trust.
- The outpatient department was open Monday to Friday 7.30am – 8pm. Evening appointment times were available for specific specialities, for example orthopaedic and gynaecology clinics, and allowed more

flexibility for patients. Saturday clinics were held infrequently, however the outpatient manager told us there was a plan to introduce Saturday clinics for consultants who were interested to allow patient demand to be met.

- Evening outreach clinics were held in Newton Abbot for orthopaedic first consultations and follow-ups, approximately three patients were seen each month. This was more prevalent in the winter months to improve access for patients who lived closer to this location. Nurse staffing was provided by the outpatient department. Consideration was being given to an outreach clinic located in Teignmouth, this would not require staffing by the outpatient department.
- Open days were held at the weekends to provide patients with a free consultation for advice and discussions. For example orthopaedic open days and cosmetic surgery open days.
- All bariatric patients were booked to see the psychologist and dietitian. Clinics were held in line with patient demand, at least once a month.
- Since the addition of the third theatre the diagnostic imaging staff no longer needed to be available for theatre imaging at weekends. Staff days were only extended if clinics overran during the week.
- The physiotherapy service provided week day appointments to private patients.
- The environment for the outpatient and diagnostic imaging service was sufficient. Comfortable seating was present in waiting areas, magazines were available and there was a small play area for children visiting the department. Patients and visitors had access to female, male and disabled toilets. The separate premium care lounge for private patients offered bottled water and hot drinks. The NHS waiting area offered a water fountain and payable hot drinks. The NHS waiting area also included a television which was also used for advertisement of the hospital services.
- Free car parking was available for patients, to include two disabled spaces. Staff were required to park in a separate car park to ensure spaces were available for patients. One patient commented how they found car parking a challenge due to the small size of the car park. Car parking was particularly tight on the days of the mobile screening service unit, which took up seven car parking spaces.
- The outpatient department was located on entering the hospital and therefore signage was not required. There was no clear signage to the physiotherapy and cosmetic suite department, but patients were given instructions on how to access these departments.
- We were informed patients were only provided with a hospital map and directions on request. However, patients received a letter which included the address of the hospital and the contact details should they have any queries.
- Patient comments and feedback were collated and sent to departmental managers, to include comments from the friends and family test. Departmental managers said they could make changes to the service being provided in line with these comments.

Access and flow

- The hospital met the national indication of 18 week referral time to treatment for incomplete and non-admitted patients. We observed the breach dates recorded on patient notes so staff were aware when booking patients and could manage in line with the 18 week referral time. The NHS indicative wait times for outpatient appointments in September 2016 were:
- Cataract: 6-8 weeks
- Dermatology: 2-3 weeks
- Gynaecology: 2-3 weeks
- Ears, nose and throat: 2-3 weeks
- Gastroenterology: 8-10 weeks
- General surgery: 2-3 weeks
- Orthopaedic: 2-3 weeks (hip, knee and shoulder/elbow), 6-8 weeks (hand/wrist), 12-16 weeks (foot/ankle)
- Patients spoken with said they were able to access appointments easily and quickly. NHS patients could access appointments via the choose and book system,

this allowed flexibility in selection of appointment days and times. For private patients, medical secretaries aimed to book patients an appointment time which was convenient and suitable.

- We were informed consultants regularly put on additional clinics to meet patient demand. For example there was a 12-16 week wait for foot and ankle orthopaedic first appointments and there was a high demand for private cosmetic surgery appointments so consultants held extra clinics.
- Prior to the first appointment in the outpatient department patients were sent a letter which stated 'you may need to undergo a pre-assessment and therefore allow two hours', this aimed to manage patient expectation and also allowed for pre-assessment imaging to be completed on the same appointment date to reduce multiple appointments.
- If patients required a same day or next day appointment we were informed this could normally be accommodated. At the time of the inspection one patient arrived and had the incorrect appointment time. The receptionist spoke to the consultant and arranged to fit the patient in so they did not have to return at a later date.
- For private patients first appointments were 30 minutes to allow time to ask questions, follow-up appointments were 15 minutes. For NHS patients all appointments were 15 minutes. A consultant would request a longer appointment if required to meet an individual's needs.
- During the inspection patients were not kept too long once they arrived in the department. Staff said waiting times once in the department was not an issue. The outpatient department did not monitor waiting times, although the time of patient arrival was captured on the electronic system. We observed one patient in the waiting room being advised of a 15 minute delay, the patient was offered refreshments while they waited. The patient was provided with an apology when called for their consultation. Staff said on occasions patients may need to wait in the department, in this instance refreshments were offered. Food could be offered if a patient is diabetic. If there was a particularly long wait and patient was at the end of the list they may be cancelled and a new appointment made. If a consultant was running late in theatre, which subsequently delays their clinic, patients could be called in advance to inform of delays and arrange a suitable time. An example was provided of patients mobile numbers taken to allow them to not wait in the hospital and to be called with an appointment time.
- We were told by staff it was not common for clinics to be cancelled, this usually only happened due to consultant illness, but in the event of cancellation patients would be rebooked in a timely manner. We were not provided with cancellation rates.
- Patients who did not attend (DNAs) their appointment were phoned by the healthcare assistants to check patients were okay. Patients were allowed three DNAs. DNAs were put on a monthly head of department report.
- Follow-up appointments occurred at a timeframe dependent on the surgery. For major hip and knee patients they were reviewed at six months and yearly.
- There were no breaches within radiology. All plain film imaging was undertaken as walk in or booked appointments there were no delays upon arrival in the department. All cross sectional, and ultrasound imaging was appointed within two weeks of referral.
- Reports for all imaging modalities were available within five days, urgent findings were reported and acted upon within 24 hours.

Meeting people's individual needs

- There was a corporate policy for patients with a disability or special needs. This policy states that all patients with a disability or special need will have their particular need recognised and responded to appropriately.
- Cosmetic surgery patients could be seen on numerous occasions within one consultation fee. This reduced the risk patients would not return to discuss concerns due to financial pressures.
- Psychologists were available on the staff bank for patient referrals. All bariatric patients were supported through referral to the psychologist. Cosmetic patients could be referred at the discretion of the consultant, however the outpatient manager said they were not aware of any cosmetic patients being referred. There was not a clear process for identifying cosmetic patients

who could be supported and assessed by a psychologist, or training for nursing staff in identifying patients at pre-assessment who may need further support with their decision.

- A bariatric patient group forum had been held once in the hospital in the month prior to the inspection, this was originally championed by the local acute trust. All bariatric patients were invited and given the opportunity to talk. We were told the first forum held was successful.
- Patients were not routinely informed about transport options or transport arranged. However, a patient administrator provided an example of a patient who could not attend their appointment due to transport not being available, they informed the patient to contact the NHS patient transport service and were provided with a number.
- Patients completed an outpatient questionnaire which provided them with the opportunity to inform the hospital of any additional needs, questions included 'do you have any communication problems of special learning needs' and 'will you require an interpreter'. Individual needs or special requirements were also recorded on the booking system identified during the referral process. If any particular needs of a patient was not identified through these methods they could be highlighted at pre-assessment to ensure arrangements were in place for patient admission through to discharge.
- A language line for translation was available to the hospital. This was not displayed to patients, however was asked as part of the questionnaire.
- EIDO healthcare patient information leaflets were available in the outpatient department. These were printed in larger print for cataract patients. The general manger informed us copies in braille could be requested.
- A hearing loop, to improve the quality of sound and reduce background noise, was installed in the outpatient department for patients who were hard of hearing.
- The departments were accessible for patients and visitors who used a wheel chair. The physiotherapy assistant explained how they will check a patient's needs before an appointment and provided an example of when they had met the patient or arranged for the porter to meet the patient in the car park with a wheel chair if required.
- There were no specific arrangements for patients with complex needs, learning disabilities or people with dementia, however staff said this would be managed on a case by case basis dependent on the patient's individual needs.
- Dietary requirements for a patient were discussed at their pre-assessment and a record was completed to inform the kitchen of these requirements and the date of their inpatient stay.
- The hospital could not provide us with a clear account of how they were meeting the NHS England's Accessible Information Standard. This standard sets the framework for how NHS providers meet the information and communication support needs for patients who have a disability, impairment or sensory loss. However, the hospital was achieving some of the standard, for example by asking patients within the questionnaire about their requirements and providing access to language translators.

Learning from complaints and concerns

- The general manager was the complaints lead. The matron was the clinical lead for complaints and had undertaken root cause analysis training in a previous role, the matron had a Ramsay corporate root cause analysis course booked but not yet undertaken. Complaints were logged on the electronic risk management system. Complainants were acknowledged, complaints investigated and a written response provided in line with policy.
- Complaints were discussed at the senior management team, heads of department, clinical governance, health and safety, medical advisory committee, departmental meetings and daily briefing, as appropriate. One complaint was with regards to patients receiving their histology results in a timely manner. As a lesson learnt from this complaint an audit trail was introduced when samples were sent off-site.
- Staff spoken with said they would be made aware of complaints received by the hospital particularly if they were relevant to their role or if lessons were learnt.

Requires improvement

Outpatients and diagnostic imaging

- Between April 2015 and March 2016 20 complaints were received relevant to the whole hospital, one complaint was referred to the ombudsman or independent healthcare sector complaints adjudication service.
- Patients who raised concerns received both an apology and a thank you for providing a valuable opportunity to review and improve the service offered.
- Complaints leaflets were clearly displayed and available to patients in waiting areas of the departments.
- We were informed meetings had been held with the hospital commissioners to look at trends in complaints and review complaints for consultants on practising privileges.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

Overall, we have rated well-led of the outpatient and diagnostic imaging service as requires improvement because:

- There was not an effective governance framework or strategy to support delivery and good quality care.
- There was no departmental risk registers to allow risks to be recorded and managed locally and staff were unaware how to escalate risk to the register.
- The audit programme was hospital wide and did not allow issues and actions at a departmental level to be identified.
- There were gaps in the audit programme with poor reporting and a lack of assurance the audits were accurate or being reviewed regularly with actions addressed.

However:

- Staff knew and understood the five corporate values 'The Ramsay Way'.
- The outpatient and diagnostic imaging service had visions for their departments to allow them to improve and expand for sustainability and to meet the needs of the local population.
- The outpatient department were innovative when introducing their pre-assessment system, following its success it was introduced to other Ramsay hospitals.
- Staff were highly positive about their departmental managers and the hospital management team.

Vision and strategy for this this core service

- The hospital followed the corporate set of values 'The Ramsay Way', this included five values. All staff were aware and could recite these values.
- The general manager told us they were committed to deliver high quality outcomes for patients and ensuring long term profitability. They aimed to lead the way in healthcare provision through innovation and attention to detail.
- Annually the general manager arranged heads of department and senior management team away days which were designed to review the hospital's vision and strategy.
- Talking to the team in the outpatient department they saw themselves as the 'window to the hospital'. They aimed to deliver good quality patient care as the experience of the patients in outpatients is the start to their patient pathway.
- The vision for the outpatient and diagnostic imaging service was to advertise and expand services and implement new services where there was a gap in the local marked. For example the outpatient manager told us how they wanted to improve the health screening service they had made available privately to patients, making it more accessible to people and increasing advertisement.
- The radiology service manager talked about their vision specifically for the diagnostic imaging department. They explained x-ray numbers were declining due to there being no direct GP referral for magnetic resonance imaging and the department wanted to expand this service. The department had also recently acquired the imaging contract for the Ministry of Defence in the South West and the department were excited about the potential growth of the service. There had been an additional growth in the spinal imaging workload and

staff were enjoying the greater variety of theatre cases they were involved in. There were plans to put a business case forward for a static computed tomography scanner.

- There was no clinical strategy written for the hospital however the matron who was new in post planned to engage staff in the hospital to formulate a local strategy.

Governance, risk management and quality measurement for this core service

- There was not an effective governance framework to support delivery and good quality care. We were told the hospital were hoping to achieve sustainability after a period of unrest in the absence of a full time matron.
- The senior management team oversaw all committee groups within the governance structure. We were told the senior management team met weekly with the exception of days of heads of department meetings or bank holidays, meeting minutes reviewed supported that approximately two meetings a month were held. Within these meetings discussions were held surrounding hospital activity, financial forecast, agency, legislation and corporate policies, significant events and incidents, complaints, national and local committee feedback, clinical performance, facilities and estates, audits and business developments.
- The clinical governance committee met every two months. Meeting minutes showed meeting continued even if they were not quorate, this demonstrated a lack of authority over decisions made. On review of meeting minutes area of discussion included complaints and incidents, review of reports from clinical committees, guidance and legislation, policy update, audit update and risk register update. A monthly governance report was sent to corporate governance.
- The Medical Advisory Committee (MAC) met quarterly. This committee was responsible for advising on the suitability of consultant applications for practising privileges, there was evidence of new applications being reviewed and agreed in meeting minutes. The committee did not look at clinical or quality audits. There was consultant representation across all specialities, however the meeting minutes identified poor attendance. The radiology representative had sent their apologies for December 2015, and both January and May 2016.
- Head of department meetings were held monthly and a monthly head of department report was produced. We reviewed meeting minutes and each department contributed. Discussions were held around hospital activity, financial forecast, agency usage, new legislation, alerts, staff sickness and turnover, training, significant events, complaints, risk register and audit.
- A Regional finance manager visited the hospital regularly and met with Heads of Department to review financial performance. The Finance manager also met with the senior management team in the hospital to review financial performance.
- Daily morning briefings included representation from each department, this was predominantly head of departments. Staff in outpatients told us they had represented if the outpatient manager was not available. We observed a morning briefing and staff were given the opportunity to raise any issues or concerns from the previous day. They covered medication recall, safety, security, maintenance, complaints, incidents and catering during the observed briefing. Staff felt the meetings were effective and we saw evidence of this information being cascaded to staff by heads of department in the form of an information folder after the meeting
- Departmental meetings were not held regularly. These meetings provided an opportunity to feedback from the head of department meetings, however were not in line with the regularity of head of department meetings. The physiotherapy team told us their monthly departmental meetings had become less frequent. The outpatient department held meetings quarterly, however in the interim had a communication book. We evidenced monthly meeting minutes for the diagnostic imaging department where incidents, service provision, training, compliance and risks were discussed.
- The diagnostic imaging service felt they had good processes internally and at corporate level to ensure systems were reviewed and improved. The radiation protection committee met at corporate level which was attended by the local radiology lead and the radiation protection advisor. The radiology lead attended a regional team meeting where all diagnostic leads were involved including the head of diagnostics. The radiation protection advisor produced an annual report for the department around compliance against the

radiation regulations and any areas required to be addressed. The radiology service manager and the clinical radiologist met weekly to discuss the department and its needs, although this was an informal meeting it was felt to be effective. Local rules were evidenced as required under Ionising Radiations Regulations 1999 (IRR99) and were within review dates. IRR99 are a statutory instrument, which form the main legal requirements for the use and control of ionising radiation in the United Kingdom.

- A customer quality focus group met quarterly to triangulate patient feedback through review of patient satisfaction, issues, service improvement, ideas and friends and family feedback. There was staff representation from different departments across the hospital.
- There was not a systematic programme of clinical and internal audit to monitor quality. The audit programme was hospital wide and therefore did not allow issues and actions to be identified at a departmental level. We saw evidence of completed audits however these were not always regular or accurate and did not always include a good representative number being audited. We could not confirm actions as a result of audits were followed up and complete. There was poor quality reporting, for example only three staff members were used to confirm hand hygiene compliance.
- Arrangements for identifying and managing risks with mitigating actions were not evident at a local level. There was a corporate risk register but no departmental risk registers to allow risks to be recorded and managed at a local level. Heads of department were unable to identify what was on the risk register and were unaware of how to escalate risks so they were put onto the register. Risk assessments were completed at departmental level and we saw evidence these were reviewed annually, however updates weren't always made in line with changes. For example the possible reaction to allergies risk assessment for the outpatient department states resuscitation equipment and drugs was readily available in the room where allergy and skin prick patch tests were completed, this was not correct.
- There were no governance procedures for managing and monitoring transfer of care agreements with third party providers. For example, the agreement for transfer of critically ill patients with the local acute NHS trust was not ratified and was overdue review.
- There were 103 consultants working under practising privileges, processes were in place to ensure consultants had an appropriate level of valid professional indemnity insurance and validated registration. Most consultants worked in the NHS, where their revalidation and appraisal was completed. Evidence of appraisal was sent to Mount Stuart, although the hospital reported temporary difficulties in obtaining annual appraisals for consultants who held substantive contracts at the local NHS Trust, this was due to changes in systems used by the local NHS Trust. For consultants employed outside of the NHS a Ramsay Healthcare accountable officer ensured consultants were suitably appraised and revalidated.
- When consultants brought registrars or assistants we were told documentation was required to ensure appropriate checks were undertaken.

Leadership

- Staff were highly positive about their departmental manager and commented how supportive their managers were. Managers were also extremely proud of their staff and described them as hard working who offer excellent patient care.
- We observed excellent local leadership by the radiology service manager and aesthetic manager. Recent changes in management had provided the physiotherapy team to be led by the aesthetics lead. This was a recent change and considered positive for the future.
- Managers attended a corporate three day management head of department training day when they started their posts.
- The outpatient manager worked clinically and was seen engaging in department activities and effectively supporting their staff. However, they did comment how this left little time for the administrative part of their management role.

- The aesthetics manager worked clinically and described how the service had grown and developed over the past years and how staff were being supported to train in new techniques for the benefit of patients.
- Staff said the hospital management team were very visible and the general manager visited the departments daily. They commented how there was an open door for them to raise issues.
- Heads of department commented on how the Matron who was new in post was very visible, supportive, and had an open door policy.
- The hospital wide staff questionnaire in March 2016 showed low scoring for corporate leadership team and senior management team. When asked if the corporate leadership team listened and acted upon employees' views and concerns only 34% of staff agreed. When asked if the corporate leadership team were visible to employees only 41% of staff agreed. When asked if the corporate leadership team communicates everything staff need to know only 46% of staff agreed.
- For 18 months there was no full time matron to act as the clinic lead in the senior management team, the new matron was in post in August 2016. There appeared to be some gaps in leadership in this interim period, for example the overseeing and scrutinising of audits and the completion of staff appraisals. The new matron was in post at the time of inspection.

Culture

- Staff spoken with felt respected and valued and enjoyed working at the hospital. They said the hospital and the environment was open and friendly, and agreed the culture encouraged candour, openness and honesty. One person said the culture involved everyone looking out for each other and for the patients in a caring and professional manner. Another staff member said there was a sense of good comradery. The culture was described on a number of occasions by staff as being like a 'family'.
- One consultant said they loved working in the hospital with the ambience and surroundings and they found the staff to be smart, professional and experienced.
- The diagnostic imaging department felt they were well regarded and perceived they had excellent relationships with senior managers and clinic staff throughout the hospital. They felt there was a great working culture within the department, which was patient focused and interactions with patients were positive. The radiology service manager was proactive in educating all clinical staff about radiation protection.
- Staff spoke about their well-being check which was part of the Ramsay benefit from a third party occupational health service. Staff were clear on how to access additional services to support them such as confidential counselling via the Ramsay benefit programme.
- Private patients were provided with terms and conditions of the services being provided and the amount and method of payment fees.
- Arrangements for advertising and promotional events were in accordance with advertising legislation and professional guidance.

Public engagement

- At the time of inspection there was limited engagement of the public and patients in the outpatient and diagnostic service, and hospital wide. However, the general manager told us they were advertising for patients to be involved in a patient experience group. This identified the hospital were actively seeking patient and public engagement.
- The outpatient and diagnostic service received feedback from patient comments via hot alerts, this included comments made with the friends and family test. Hot alerts are important updates to staff sent via email and on paper. Patients were also invited to complete a satisfaction survey online or via the telephone, however this did not include open ended questions to obtain further patient feedback and allow patients to express themselves. The response rate for this survey was low. In the July 2016 report only 25 patients provided feedback across all departments, this was a response rate of 30.6% as 68 patients received the invitation to complete feedback, this was only a small percentage of patients who would have been seen in the hospital in that month.
- We were informed that the private patient accounts manager was in contact with premium care patients directly and actively encouraged feedback on all aspects of their care and experience.

Requires improvement

Outpatients and diagnostic imaging

- The hospital held regular open events which offered the general public an opportunity to visit the hospital and meet with consultants to privately discuss specific areas of interest. Events held included orthopaedics, cosmetic, mole treatment, dermatology, headache and pain management.

Staff engagement

- Staff spoken with felt actively engaged and felt the management team were receptive. Examples were provided of suggestions staff had made which were listened to and changes implemented to improve efficiencies in the departments.
- Staff forums were held by the general manager. This forum was used to update staff on events and plans, discuss issues and allow staff to ask questions. We were provided with the staff forum presentation, there were no minutes to reflect the questions staff had raised and actions as a result. However, the general manager told us staff were very involved in the forum.
- The annual staff survey was administered by an independent company providing results by location comparative to the Ramsay group overall.
- There was a Ramsay wide customer excellence scheme which rewarded staff frequently named by patients or colleagues for 'going the extra mile'. Staff also received long term service awards.

Innovation, improvement and sustainability

- The hospital's quality account said consultant engagement meetings had stimulated opportunities to grow the business by increasing the range of services and exploring new innovating methods of practice.
- All heads of department had been given budgetary control over their area which allowed for flexibility and autonomy over purchasing.
- The outpatient and diagnostic imaging service were looking for areas to improve the service they were providing, for example offering allergy testing because there was an 18 month wait for the local acute Trust. They were also in discussions about the introduction of an out of hours GP service within the department.
- We were informed of plans for air handling units to be placed in the cosmetic suite to allow the service to expand and undertake minor surgery under local anaesthetic.
- The hospital staff were awaiting the roll out of an electronic record system, to include patient medical records, billing and pharmacy, and improve access to information.
- The outpatient manager told us they were innovative in introducing the pre-assessment one following consultation, and inviting some patients for a pre-assessment two. This was implemented at Mount Stuart and then rolled out to the Ramsay group. The introduced process had reduced the number of cancellations. Previously with pre-assessment only two weeks before surgery the department were finding approximately 35-40% of surgeries were cancelled following results from pre-assessment which indicated patients were unable to have their surgery.
- The radiology service manager stated ideas for improvement and service delivery were listened to by managers locally but there was no clear understanding of the corporate view of the innovation and service expansion that was being suggested.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The information used to monitor performance was not used to change and improve practice. There were not clear governance processes in place to monitor the service provided. Audits were not regularly completed. Actions seen as a result of audits were not followed up to ensure they had been completed.
- There was not a complete and accurate systematic programme of clinical and internal audit to monitor quality systems and identify action. Audits were not regularly completed and the results available were not regularly reviewed to ensure they were adequate. Actions seen as a result of audits were not robust or followed up to ensure they had been completed. The provider must have in place a complete and accurate systematic programme of clinical and internal audit which can be used to monitor quality systems to identify what actions should be taken. Comprehensive audits should be completed specific to departments to allow performance and compliance to be monitored at departmental level.
- There were no local risk registers in place and no department ownership of how risks were identified and managed. The provider must ensure that risks are monitored and used to prompt actions.
- The management of duty of candour was well understood by staff but its implementation not consistently practiced. The provider must ensure staff understand and follow the duty of candour.
- Cosmetic surgery services did not follow the company policy. Psychological reviews must be considered, recorded or undertaken to ensure that appropriate consideration had been given around body image and patient expectations. There was no record of the cooling off period of time between initial consultation and the date for surgery. Consent for cosmetic services must be in line with company and national guidelines.
- The provider must ensure the arrangements to respond to a medical emergency in the outpatient and diagnostic imaging departments are clear amongst staff, practiced regularly and be assured the resuscitation equipment is readily available. The provider should review the single use resuscitation bag present in physiotherapy department.
- Resuscitation scenarios as a practice exercise had not taken place since July 2014. A resuscitation team had recently been implemented and part of their role was to plan and produce these scenarios. This had not yet taken place and training for this role was not planned until November 2016. The provider must ensure that care is provided in a safe way for patients.
- There had been unsucessful forward planning following the development of theatre facilities to include increase in theatre staff and cleaning staff. The provider must ensure that there are sufficient staff with sufficient skills employed at the service.

Action the provider SHOULD take to improve

- The provider must ensure management of incidents followed the hospital policy; more serious incidents were not always investigated properly.
- The provider should ensure mandatory training is fully compliant.
- Medicine systems were mostly safe, however the storage of fluid and temperature monitoring should be actioned to ensure safety.
- The management of infection control should ensure all staff were fully trained, monitoring and cleaning audits should be fully completed.
- Some areas of theatre and ward environment were in need of review, these included the completion of the theatre development programme underway and an emergency call system in recovery. The management and process of replacing damaged equipment was prolonged. These areas should be reviewed and action taken.

Outstanding practice and areas for improvement

- Agreements with local trusts for the transfer of patients in an emergency were out of date and should be updated and agreement recorded.
- The WHO checklists should be consistently audited to provide assurance they were correctly and fully completed. When shortfalls were seen, actions should be followed up to ensure improvements were made.
- Anaesthetic audits should prompt remedial action. The action plans undertaken as a result of the audit did not prompt change of practice.
- Fire drills should be completed to ensure safe practice. No fire drill had been completed in the previous 12 months, this included opening of new theatre and ambulatory care.
- Staff did not always have the complete information they need to provide care and treatment. Assessment of nutrition and hydration should be completed using an appropriate tool and so risks to patients could not always be identified. Audits of nutrition and hydration should be available to assess service provision.
- There were gaps in support arrangements for staff. All nursing and ward staff should receive an annual appraisal of their skills and performance.
- Patient theatre gowns made of thin material and small in size and should be considered for replacement to ensure patient dignity
- Quality and safety were not the top priority for leadership. The MAC was poorly attended and there was no evidence that minutes were read by members who did not attend. The provider should ensure that meeting are attended.
- Theatre management and leadership was not evident at all levels to ensure safe practice. All areas of leadership should be clear in the scope for their service delivery.
- Next day cover for the out of hours on call theatre team, should they be called in, should be in place.
- Staff should ensure all medicines are stored securely and at the correct temperature. Staff should know how to reset thermometers and what action to take when readings are recorded outside of the recommended range.
- The outpatient department should review the risk of cross infection of staff eating and drinking in a clinical area.
- The safe use of the three-part decontamination system should be reviewed and goggles should be made available for personal protective equipment.
- The provider should review the layout of the outpatient department to access the sluice and the risks of dirty items being transported through clean areas.
- The outpatient department should ensure they have appropriate stock rotation in consulting and treatment rooms.
- The provider should ensure there is a clearly documented exclusion criteria to be followed for both NHS and private patients.
- The provider should ensure processes are in place to assure themselves the consultants are abiding by the clinical photography policy and the photos being taken of patients are managed confidentially, kept secure and deleted on a timely basis.
- The provider should ensure the use of carpets in the outpatient department has been risk assessed and included on the risk register.
- The provider should consider how patient outcomes can be monitored and measured in the outpatient and physiotherapy departments.
- The provider should review how cosmetic patients are assessed for the requirement of a psychological review.
- The provider should consider implementing departmental risk registers to allow departmental risks to be recorded and managed effectively.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was not an effective operation of systems or processes in place to assess, monitor and improve the quality and safety of the services provided. There was not an effective operation of systems or processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of services users. Audits were not regularly completed. Actions seen as a result of audits were not followed up to ensure they had been completed. These included: • There was no ongoing management of infection control. Audit tools and observation were not being used to monitor the infection prevention practice. This included hand hygiene and cleaning audits. • Records maintained of the deteriorating patient early warning scores (EWS) had been audited, shortfalls found and actions put in place. No follow up audit had taken place to ensure patient safety. • The assessment of actions taken to prevent venous thromboembolism (VTE) had been undertaken but not reviewed to ensure an improvement had taken place. • Audits of records had taken place, but re-audit had not shown an improvement. • Surgical site infection audits had not been reviewed since May 2016 to identify if practice was effective. • Some audits were not completed to ensure an effective service was being provided. This included audits of cosmetic surgery.

This section is primarily information for the provider

Requirement notices

- There were no local risk registers in place and no department ownership of how risks were identified and managed.
- There was not a complete and accurate systematic programme of clinical and internal audit to monitor quality systems and identify action. Comprehensive audits were not completed specific to departments so performance and quality was not monitored at a departmental level.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour • The management of duty of candour was well understood by staff but its implementation not consistently practiced after an incident had occurred.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Cosmetic surgery services did not follow the company policy, psychological reviews had not been considered, recorded or undertaken to ensure that appropriate consideration had been given around body image and patient expectations. • Consent for cosmetic services was not in line with company and national guidelines. • Resuscitation scenarios as a practice exercise had not taken place since July 2014. A resuscitation team had recently been implemented and part of their role was to plan and produce these scenarios. This had not yet taken place and training for this role was not planned until November 2016. • Arrangements to respond to a medical emergency in the outpatient and diagnostic imaging departments were not clear amongst staff or practiced regularly to

This section is primarily information for the provider

Requirement notices

be assured the resuscitation equipment was readily available. A worn single use resuscitation bag was present in physiotherapy department and posed a risk of confusion amongst staff.

- The hospital were not compliant with the Royal College of Surgeons professional standards for cosmetic practice. Consent was not obtained in a two-stage process with cooling off period of at least two weeks between stages to allow patients to reflect on their decision.
- Non-compliant sinks with plugs and overflow were present in the outpatient and physiotherapy departments