KIMS Hospital Limited

Kent Institute of Medicine and Surgery (KIMS)

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Not sufficient evidence to rate
Services for children and young people	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

KIMS Hospital is an independent acute hospital run by KIMS Hospital Ltd. It provides care and treatment for private (self-funded and insured) and NHS patients referred under the Standard NHS Acute Contract. The hospital is located on the outskirts of Maidstone and close to the M20, providing easy access for people travelling from other areas of Kent. The hospital is newly built and first opened to admissions in April 2014. The hospital has 81 overnight inpatient beds and 20 day care beds.

The hospital offers a variety of services including elective surgery, medical care, outpatients and diagnostic facilities. The hospital has a level 3 critical care unit that is provided following elective surgery on a planned basis only. Children under 16 years of age are only seen in the outpatient clinics and no procedures except blood tests and x-rays are undertaken on children. The provider is aware that services for children are not yet sufficiently developed to allow for inpatient or day surgery admission and has agreed to withhold introduction of these paediatric services until they have the agreement of the Commission.

Day surgery and inpatient treatment is provided for patients across a very wide range of specialties, including urology, ophthalmology, orthopaedics, ear, nose and throat (ENT), gynaecology, endoscopies, general surgery (such as upper and lower gastrointestinal surgery) and cosmetic surgery. The majority of procedures were for non-complex orthopaedic surgery; however, the hospital does also carry out some complex procedures including cardiothoracic surgery. Medical treatment is provided as both outpatient and inpatient care across numerous specialities including neurology, dermatology, cardiology and respiratory medicine and a limited amount of oncology. The organisation has more than 250 consultants working with practicing privileges.

The number of consultants with practicing privileges was of concern as most did not work regularly at KIMS. These consultants had an initial look around the premises but were unfamiliar with the policies and practices at KIMS. They would not necessarily be familiar with the equipment. This posed a risk to patient safety. We saw an incident report where a patient had suffered a burn as a result of a surgeon being unfamiliar with equipment.

In the year April 2014 to March 2015 the hospital admitted 771 inpatients and 1,812 day patients. There were 2,486 visits to theatre during this period. Twenty six percent of all patients were NHS funded.

Physiotherapy, pathology and catering services are all outsourced to third party contractors.

KIMS Hospital was selected for a comprehensive inspection as part of the second wave of independent healthcare inspections. The inspection was conducted using our new comprehensive methodology.

We carried out an announced inspection of KIMS Hospital between 22 and 24 September 2015. We also carried out an unannounced inspection of the hospital on 29 September 2015. The purpose of the unannounced inspection was to look at how the hospital operated at off-peak times.

The inspection team inspected the following core services:

- Surgery
- Outpatients with diagnostic imaging
- Medicine
- Critical care
- Children and Young People

It should be noted that for some core services the numbers of patients being treated at KIMS hospital was very low. The inspection team have made it clear where this was the case as evidence was based on small cohorts. The judgements

Summary of findings

are based on what we found but considered how this might impact were the demand for admissions to increase. Where local, informal, arrangements can work for small numbers there needed to be a more systematic approach in place before the service developed to capacity. This is particularly true with the diversity and complexity of treatments provided by the consultants with practicing privileges.

Maternity services, termination of pregnancy and emergency services are not provided at KIMS hospital.

We rated KIMS hospital as "Requires Improvement" overall. We saw some very good care being provided by staff and people were generally happy with the treatment they were receiving. However, the underutilisation of the hospital posed significant risks to patients as a result of staff not being able to maintain their skills in caring for acutely unwell patients. The extreme range of services offered, according to the website, results in very low numbers of some procedures.

The low occupancy levels, whilst the hospital develops to capacity, could have been utilised to create excellent services but this had not happened in some areas and was a missed opportunity. Poor governance systems, limited dissemination of learning from incidents and complaints and no real clarity about what services the hospital would or could provide had led to piecemeal development. Some services with good local leadership (such as radiology) had thrived whilst others lacked expert leadership and had failed to create a service that was able to meet people's needs (such as critical care and end of life care).

The hospital website offers a huge range of services and treatments that it cannot provide safely and creates an image that is inaccurate. The site talks about a dedicated cancer care suite and chemotherapy service for people diagnosed with cancer. There is a single haematologist with practicing privileges. The hospital is not resourced to provide chemotherapy safely.

Similarly breast care services are advertised as an integrated facility providing a one stop clinic for consultation and diagnoses of potential breast cancers. A one stop clinic has not been established and any women seen or treated are being provided with a service outside of the National Institute for Health and Care Excellence guidance (NICE).

Are services safe at this hospital/service

Overall we rated 'Safe' as requires improvement because three of the four core services we rated required improvements. Critical care was not rated as we could not observe patient care but we did identify areas for improvement.

- Many of the staff we spoke with were not clear what their responsibilities were in relation to the Duty of Candour. The provider had supported staff with training and there was a policy in place.
- The organisational learning from incidents was not robust enough. The dissemination of learning was very localised; opportunities for wider learning were missed.
- The Medical Director (MD) felt RCA investigations should only be completed, "Under certain circumstances". The circumstances were unclear. The learning potential for the organisation did not resonate with the MD.
- Much of the management and assurance about consultant behaviour talked about by the MD centred around strong leadership by the theatre manager. There was little assurance regarding how the behaviours and compliance of physicians was monitored or managed.
- There were no Mortality and Morbidity meetings to review patient outcomes and highlight specific areas of concern.
- The Medical Advisory Group (MAG) was responsible for oversight of medical and surgical practice within the hospital. The MAG did not have information on clinician's performance from the trusts where they were employed. This meant there was no governance to ensure that consultants carry out best practice and adhere to national and local policy.
- Letters regarding poor practice for three surgeons that had been copied to KIMS and the local NHS trust were not shared with the MAG. The chair was unaware of the letters.
- There were no formal Multi-Disciplinary Team (MDT) meetings for cancer services but they were held for cardiology.

Summary of findings

- The very low occupancy levels of the hospital resulted in a risk that staff could not maintain their skill and knowledge base. This was particularly true of critical care staff and those caring for patients having complex surgery.
- There was insufficient oversight of the endoscopy service. The endoscopy suite was not fit for purpose. Reversal agents were not readily available to patients being recovered as they were kept in a room where another patient was already sedated.
- There was no access to specialist palliative care staff. The hospital did not have any specialist assessment tools for end of life care. There were very few patients who died at KIMS (because the patient numbers were so low) but we were not assured that the systems were in place to ensure those that were dying received properly planned and expert care.
- Not all staff followed the hospital Infection Prevention and Control Policy. The policy had not been ratified.
- There were carpets in some ward and clinical areas. This is not in accordance with Health Building Note 00-09: Infection control in the built environment.
- The emergency call system was broken for an extended period of time. The provider was aware of this and failed to provide a solution in a timely manner.
- Medical records failed to demonstrate where and when a patient was followed up following surgery at KIMS. This included cancer patients where the follow up arrangements were unclear.
- There was no major incident plan that was known to all staff.
- The critical care unit was not always adequately staffed. Low occupancy levels had led to changes to the staffing arrangements that resulted in a requirement for flexible working. This flexible working system meant that nurses were sometimes working excessive hours. This included working a double shift with no time off. The informal escalation process meant staff could be called to work during their off duty time.
- Staffing on the critical care unit did not meet the national guidance on staffing levels and use of agency staff issued by the Intensive Care Society.
- There was a disconnect about the use of critical care facilities with staff on the unit telling us they could only accept pre-booked patients following elective surgery, whilst the staff caring for patients on the ward told us that a deteriorating patient could be transferred to the critical care unit (CCU).
- The governance structure did provide assurance for the board around incidents, alerts and risks. There was a mechanism for escalating risks and some analysis of incidents and trends.
- Ward level meetings fed in to the Clinical Effectiveness Group.
- Handover arrangements between the two Resident Medical Officers (RMO) was good.
- Consultant advice and support was readily available when the RMOs had concerns about patients.
- The arrangements for the management of medicines were satisfactory.
- There was a named lead for safeguarding but no named doctor for either adult or child safeguarding.
- Staff had a good understanding of the safeguarding policy and had completed safeguarding training appropriate to their roles.
- Facilities management was sound and included routine testing and run off from water outlets to reduce the risk of Legionella.
- There was good oversight and management of clinical waste disposal, including sharps.

Are services effective at this hospital?

Overall, we judged KIMS Hospital to be 'Good' for the Effective Domain. One core service was rated as requires improvement and two others were not rated as there was insufficient data and other evidence to form a clear judgement.

- Observed treatment and care was in line with national guidance but there were examples where national guidance had not been adhered to.
- Pain was well managed for the patients we spoke with.

Summary of findings

- Risk assessments were used to inform care planning and delivery for all admitted patients. This included assessment of the risk of malnutrition, pressure damage, falls and venous thromboembolism (VTEs).
- Staff were competent and committed to maintain their skills despite the small number of patients being cared for.
- There was very limited review of patient outcomes. Cohorts of patients were too small for participation in many national audit programmes, except the national Joint registry.
- There was no clear audit plan and programme. Auditing within the hospital was in its infancy.
- We did see some responsive auditing (such as an unexpected rise in surgical site infections that was being reviewed by the RMO).
- Outcomes for individual patients were not monitored and there was no benchmarking between individual consultants. Follow up documentation was sparse.
- Practicing privileges were granted to many consultants some of whom had never worked at KIMS since. The practicing privileges were for two years, after which time they would be reviewed.
- Appraisal records were sought from all non NHS consultants and a sample of NHS employed consultants but here was no other system for monitoring compliance with the practicing privileges.
- Breast surgeons operated on women at KIMS however, there was no dedicated breast clinic and no access to triple testing on initial referral as recommended in NICE Guidance CG 80.
- There was no guidance about prescribing anticipatory drugs for patients approaching the end of life and no expert advice available regarding appropriateness of medicines that were prescribed to control symptoms.
- Consent prior to surgery was well documented and staff adhered to the WHO Surgical Safety checklist which included rechecking valid consent had been given prior to any procedures.
- The children's nurses had a good understanding of the national guidance on seeking consent from children and young people.

Are services caring at this hospital?

We rated the 'caring' domain as 'Good' across all core services that we reviewed.

- There was a very positive atmosphere, with staff clearly enjoying their work, this had a positive effect on the way they delivered care.
- We observed good relationships between patients and staff.
- People told us that they were well cared for and that staff treated them with dignity and respect.
- One advantage of the low occupancy rates was very individualised care and staff with time to listen and provide for patients personal preferences.
- There were some simple but effective measures in place to make people felt well cared for. This included a supply of umbrellas that visitors to KIMS could use when it was raining.
- Friends and family scores were good, and these were used to benchmark how scores relate to patient experience.
- There were counsellors who worked on the site and patients could be referred to these if they wished.

Are services responsive at this hospital?

Overall we judged the domain 'Responsive' as requires improvement. There was due to a lack of effective service planning. The hospital was operating well below capacity and the additional resources this gave the staff should have been used to ensure that appropriate governance and monitoring systems were in place to identify shortfalls.

There was a lack of data collation and analysis and what information was available was not used to inform service planning. The spare capacity was not well used to develop services, such as high quality end of life care provision.There was a high number of cancelled appointments. The time from referral to first appointment averaged 29 days which was a long time for a service providing for such low numbers of patients.

Summary of findings

- Service planning was in transition with a new Chief Executive Officer (CEO) implementing a change in focus and service delivery to make the hospital more sustainable. The very low occupancy rates meant service planning was difficult in specialist areas such as critical care which operated on an ad hoc basis.
- At the time of the inspection, individual needs and preferences were being met very well. The low patient numbers allowed for more nursing time for each patient.
- The hospital had access to a telephone translation service but not all staff were aware of this. There were times when a translator should have been used (such as when seeking consent) but the service had not been provided.
- Dementia care was not well developed but the service had not had to care for many people who lacked capacity. Staff understood the concept of mental capacity well and were able to describe how they would adapt the care they provided to meet the needs of someone with dementia.
- There was no document detailing which procedures consultants were permitted to carry out at KIMS hospital and no explicit exclusion criteria to prevent the admission of patients who the hospital was unable to manage the care of safely.
- Access to KIMS was via a referral from a GP, another consultant or self-referral by patients.
- Appointments were readily available and there was no waiting list for treatment.
- There was no rapid discharge policy for patients approaching the end of their life. This meant people could not be transferred to their preferred place of care and death in a timely manner.
- The policies for end of life care had not been ratified and there was little guidance available to staff on how best to meet someone's needs as they approached the end of life. There was no system for identifying patients who were requiring end of life care. Links with local palliative care providers had not been developed.
- The critical care unit was not fully operational and only accepted patients following elective surgery. The hospital website described a level three critical care unit but did not say this was not available to patients whose condition deteriorated rapidly. Patients who needed critical care in an emergency were transferred out to a local NHS facility.
- Learning from complaints and concerns was limited. Some complaints were logged as incidents rather than complaints. Informal complaints were not logged or monitored at all. This was a missed opportunity for learning.

Are services well led at this hospital

Overall we judged the leadership of the hospital as 'Requires Improvement'. This was because there was a lack of robust governance. Learning from complaints and incidents was localised and the organisation missed opportunities for wider sharing of learning.

- Three of the four core services reviewed rated this domain as 'Requires Improvement'.
- The hospital was still very new and was developing their vision and strategy. There had been some changes of senior management and this had led to changes in how the service was moving forward. At the time of the inspection, it was too soon to see the impact of these changes.
- The hospital was led by the senior management team which included the Chief Executive Officer and the Director of Patient Services.
- The hospital management board met weekly and had both a strategic and operational focus. The board is made up of investors but is attended by the MD.
- The board had received training on their responsibilities as a board member, including Fit and Proper Person (FPP) training.
- The hospital undertook a schedule of FPP checks annually.
- The culture appeared good with staff almost universally saying positive things about the managers of the hospital. Local managers were said to be supportive and approachable.
- Staff were engaged and described an open culture where they felt they could raise issues or concerns and positively influence the services they were providing.

Summary of findings

- The clinical leadership of specific services was not sufficiently developed. This included a lack of senior clinical oversight with expertise in end of life care, infection prevention and control, critical care nursing and children's services.
- There was no clear audit plan for the service.
- Informal complaints were not recorded which meant the full picture of any trends was not available. Informal complaints were not reported as part of the governance structure.

We saw several areas of outstanding practice including:

- The radiology department was providing an excellent service using the most modern equipment available.
- The development and management of the Cath Labs was of a very high standard. Staff demonstrated a strong patient centred approach with the policies, procedures and robust monitoring and checks in place to provide a safe service for patients. We also found strong multidisciplinary working and a proactive approach to ensuring good access and flow for patients that supported consultants and other staff needs. The service had built links with local NHS hospitals and provided facilities that assisted in their management of capacity or if their service suffered interruption. This ensured that patients that otherwise may have had to be cancelled received their treatment and procedures. This had in turn led to a strong support network between KIMS and the NHS hospitals with opportunities for shared practice and improvements.
- The facilities management was very good.

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

Importantly, the provider must:

- The provider must put in place arrangements for end of life care patients to be referred to palliative care specialists and to be included in local palliative care multidisciplinary team networks.
- The provider must finalise the policy for end of life care, the end of life patient needs assessment and care planning tool, and end of life medication guidance and must make these available to staff.
- The hospital must review their website to ensure its not advertising surgical procedures and a level of intensive care that cannot currently be provided at the hospital.
- The provider must ensure that the staffing on the critical care unit meets the national guidance on staffing levels and use of agency staff issued by the Intensive Care Society.
- The hospital must cease offering diagnostic investigations, treatment and surgery to women with suspected breast cancer until such time they can provide a comprehensive diagnostic and support service.
- The hospital must ensure flooring in clinical areas complies with the requirements of Health Building Note 00-09: Infection control in the built environment. Carpets must be removed from areas where patients are cared for or treated.
- Develop a scope of practice document that includes details of all permitted procedures. This should include exclusion criteria so that staff and consultants are made aware of the limitations on their practice.
- Review the arrangements for the senior management oversight and provision of endoscopy services.

In addition the provider should:

- The hospital should appoint a clinical lead for end of life care and nominate an Executive Committee member with responsibility for end of life care.
- The hospital should put in place an effective governance framework to support the delivery of good quality end of life care. This must include admission criteria to ensure that only patients whose needs can be effectively met at the hospital are admitted there for end of life care.
- The hospital should ensure that staff who deal with patients at the end of their lives are suitably trained and competent to do so.

Summary of findings

- The hospital should ensure that there are formal processes in place to audit end of life care and to learn from incidents so that care can be improved.
- Staff undertaking RCA investigations should be provided with training to ensure they have the skill to complete the report in a sufficiently robust manner.
- Arrangements for the granting and monitoring of practicing privileges should be strengthened.
- The Hospital should ensure that all staff are aware of what a 'Never Event' is.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

We carried out an announced inspection of KIMS Hospital between 22 and 24 September 2015. We also carried out an unannounced inspection of the hospital on 29 September 2015. The purpose of the unannounced inspection was to look at how the hospital operated at off-peak times.

KIMS was inspected as part of our second wave of comprehensive inspections of independent healthcare providers. The hospital was selected because it is a new service offering complex treatments and we had very little intelligence on the quality of care and treatment.

Overall we rated the service as 'Requires Improvement' because most of the core services that we reviewed were requiring improvement. Most of the issues we identified were already known to the provider and they had taken steps to introduce changes but many of these were too recent to have had a significant impact. In discussion with the executive team, it was clear they were committed to providing a high quality service and knew how to achieve this but were still developing their assurance framework.

Underutilisation of the hospital was a serious problem for the provider. Use of the service had not been as high as initially projected and the board and executive team were reviewing how they provided services to address this. In the interim staff were at risk of losing their skills and there was a lack of clarity about exactly what KIMS hospital offered.

A new governance manager had been appointed and was aware of what needed to be done but in the two weeks they had been in post they had not had sufficient time to demonstrate a real impact.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We judged that the safety of services requires improvement.

The governance structure and assurance framework was not fully established and needed further work to ensure that there was optimal learning from incidents.

The low occupancy levels posed a risk that staff would not be able to maintain their professional skills.

The very large number of consultants with practicing privileges posed a risk that they would see patients and provide treatment in an unfamiliar environment where they were not used to the equipment and did not know the local policies. There was evidence where a patient had suffered harm as a direct consequence of this unfamiliarity.

There was no formal scope of practice document that made explicit to consultants which procedures were permissible at the hospital. This posed a risk that consultants might undertake procedures that the hospital was not properly resourced to support.

End of Life Care provision was in its infancy and the provider had not developed the service sufficiently to ensure that peoples palliative needs could be met.

There were improvements needed in medicines management in the outpatient department.

The use of carpets on floors in clinical areas did not conform to national guidance on infection prevention and control.

The child safeguarding arrangements did not comply with the national guidance.

Are services effective?

Good

We found that KIMS was providing an effective service.

Staff were competent and the hospital management team has provided additional support to help staff maintain their skills. However, there remained a risk that some staff would not be able to maintain their skills because they had so few patients (in critical care, for example).

There was good multi-disciplinary relations within the hospital.

Summary of findings

Patients reported good pain management, although a lack of Palliative Medicine expertise meant that people being cared for at the end of life might not have the most appropriate anticipatory medicines prescribed for their needs.

Staff were following national guidance in the management of most patient conditions. However, the care and management of patients with potential breast cancer was not provided in line with NICE guidance.

There was low use of Do Not Attempt Cardiopulmonary Resuscitation forms. Those that were seen were incorrectly completed.

Are services caring?

Good

We rated the quality of caring as 'Good'. Critical care was not rated as the inspecting team were unable to observe any direct patient care or contact.

All patients that we spoke with were positive about the care they received and reported that staff were kind, attentive and very helpful.

Direct observations showed that all staff were courteous towards visitors. Nursing staff were gentle and supportive to patients.

Are services responsive?

Good

We judged the responsiveness of the service as 'Good'

In general, peoples' individual needs were well met by the staff.

Service planning was in transition with a new CEO implementing a change in focus and service delivery to make the hospital more sustainable. The very low occupancy rates meant service planning was difficult in specialist areas such as critical care which operated on an ad hoc basis. Staff were unclear about whether the provider allowed use of the critical unit in an emergency or whether a deteriorating patient needed to be transferred to a local NHS facility.

The policies for end of life care had not been ratified and there was little guidance available to staff on how best to meet someone's needs as they approached the end of life. There was no system for identifying patients who were requiring end of life care. Links with local palliative care providers had not been developed. The numbers of patients requiring end of life care was low and this posed a risk of the hospital providing a service that they were not properly resourced for.

Service planning for the outpatient service was not well developed with limited data on which to build a responsive service. There were high number of cancelled appointments and clinics.

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Some staff had introduced some initiatives such as a butterfly logo for when a dying person was being cared for. This was poorly led and researched as the butterfly logo is nationally recognised as a scheme to improve hospital services for people living with dementia. An agency or bank nurse could be easily confused by this.

Are services well-led?

Requires improvement

Overall we rated the well led domain as 'Requires Improvement'.

There were significant shortcomings in the assurance framework and governance arrangements but the provider was aware of these and had begun to make the necessary changes.

The vision for the hospital was not very clear. The service was in transition from the original vision of a tertiary centre providing very complex treatments alongside a huge number of specialist services, to a more grounded provision that was looking to meet the needs of the local community through closer work with Clinical Commissioning Groups and local NHS Trusts. Discussions around this remained on-going and the plans had not been finalised. The hospital had yet to decide which services it wanted to offer and how these were going to be provided.

Opportunities for building very high quality services were missed. Whilst the occupancy levels were low, the hospital could have used the spare capacity to improve and learn but this had not happened. There was very limited learning from incidents and no obvious involvement of the consultant body in the learning process.

Some key clinical leaders were missing from specific services. These included a lack of senior clinical oversight of critical care and the endoscopy service. The arrangements for child safeguarding did not comply with the national framework. There was no senior paediatric nursing or medical input into services for children.

Staff were very complementary about the management team and spoke of being supported and involved.

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care	Requires improvement 	The leadership of medical services at KIMS was lacking expertise in end of life care and oversight of the endoscopy suite. There was no clear vision for medical services, which were slotted in amongst the elective surgical patients. There were missed opportunities to develop high quality services during the set up stage of the hospital when the service had significant capacity to do so. There had been a 'take all' attitude to admissions rather than a carefully planned staging of the care provision that ensured the service only admitted those patients whose needs could be fully met. The oversight of incidents and a culture of learning from mistakes was not was not embedded. Poor governance arrangements failed to ensure any lessons learned were disseminated across the organisation. We identified concerns with the Endoscopy Unit that included a lack of medicine checks, inability to access reversal drugs promptly, inappropriate storage of hazardous substance and recovery room that was not fit for purpose. Staff demonstrated knowledge and understanding of the incident reporting process and we found evidence of action and learning. However, themes and trends were not collated at organisational level. There were processes in place to ensure safe staffing levels. The hospital was managing the use of agency staff to improve continuity. Staff had access to good quality equipment. We found some policies that were out of date or required updating. There were systems in place to take account of published research and national guidance. There was also an audit programme in

Summary of findings

place but not embedded due to low numbers of patients. We found varied understanding of mental capacity assessments.
We have reported end of life care services under the medicine core service as there was insufficient evidence to rate it separately. We have considered the findings for end of life care in a proportionate manner so that comments made about shortfalls in the narrative of this section are put into the context of the very few patients who received end of life care in determining the rating.
End of life care services were not sufficiently developed to ensure that the staff could meet the needs of dying patients. There was, in effect, no end of life care service but the hospital had admitted a few patients who were in need of end of life care.
Pain was well managed. There was a good process in place for gathering patient feedback with action taken. Staff could access training and development. There were good processes for induction of new permanent and agency staff. Staff demonstrated good team and multidisciplinary working.
Patients and their relatives were very positive about their care during their hospital stay. Patients described how staff were professional and knowledgeable and supported them in a compassionate and caring manner. Staff protected patients' privacy and dignity and treated each patient as an individual.
Staff felt involved in the vision for the hospital and were happy to be working at KIMS. They described an open culture with good up and down communication. Staff felt able to express their ideas for improvement.

Surgery **Requires improvement**

We identified some concerns and rated the surgical department at KIMS hospital as requiring improvement overall. This was a

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score that reflected the need for improvements in the 'Well led' domain and inadequate rating in the safety domain. The remaining three domains were rated 'Good'.
Improvements in the way incidents were collated, investigated, learned from were necessary. The systems to report incidents through the national frameworks were insufficiently robust. The department had not developed mortality and morbidity meetings to learn from mistakes and prevent recurrence.
The emergency call system was broken. The provider knew about this for some time and identified it as a risk to patients but they still had not repaired it.
The infection control policy was not being adhered to by all staff. We observed staff failing to comply with the hospital policy on being bare below the elbows and hand washing policy. The department had only started auditing to the National Standard of Cleanliness in the NHS Schedule two weeks before the inspection. This meant there was no quality assurance about environmental cleanliness in what is considered a high risk clinical area.
Compliance in use of venous thromboembolism (VTE) prophylaxis was identified as poor. However, this was recognised by the provider and was being addressed. Recent audit demonstrated an improvement in compliance.
WHO Surgical Safety Checklists were not completed routinely.
There was no major incident plan. Staff did not have a clear understanding of what a major incident was or the role expected of them should one occur.
The governance, risk management and quality assurance processes were not robust enough to assure the provider that the care they provided was safe. A new governance manager had been appointed but they had not been in post for long enough to see an impact.

Summary of findings

Management sent staff policies before they were ratified, and others were out of date.
There was no oversight of the quality of services provided by external providers.
The provider purchased some patient services (e.g. physiotherapy) from third parties. There was no monitoring of how effective the services were.
We reviewed forty sets of medical records during the inspection which highlighted that some improvement was necessary in terms of the documentary evidence available to track patient outcomes. We saw cases where follow up should have been arranged but there was no evidence in the notes (such as GP letters or follow up appointments) to show this had been done.
There was no record that some patients undergoing surgery for cancer were followed up in accordance with local and national guidance. The risk was that the patients might not have been followed up and that the staff at KIMS were unaware of this.
Patients were involved in their care planning and had their personal preferences respected.
There were sufficient staff, with the right skills that had access to on-going training to meet patients care needs.
We found the care and treatment took account of published research and national guidance. The hospital also used the findings from local and national audits to ensure that action was taken to protect patients from the risk associated with unsafe care and treatment.
Patients who used the service were protected from the risks of abuse occurring. They had their care needs risk assessed on admission. Medical records demonstrated that identified risks were addressed. The department evidenced being able to meet peoples complex care needs for example those with learning difficulties, mental health conditions or dementia.

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We found medicines were handled and stored securely. Staff had undertaken a competency based assessment to ensure the highest standard of medicine administration.
Staff had access to sufficient equipment to ensure they could meet people's needs. We found evidence of equipment maintenance schedules and service level contacts that meant equipment was being regularly serviced. There was sufficient competency based teaching provided to ensure staff felt supported to use the equipment provided.
There was an appropriate pathway to identify and care for deteriorating patients. There was sufficient medical cover to meet patients' needs. We found adequate access to screening and diagnostics seven days a week. Care was delivered from a multidisciplinary perspective, for example physiotherapy, occupational and speech and therapy services. These services were provided by external health care providers.
Staff told us they felt proud to work at KIMS. They told inspectors the department had an open and transparent culture and patients centred approach to the work undertaken in the department. Staff described feeling respected and involved in the development of the KIMS vision and strategy.
There was evidence of a strong and inclusive leadership in the department. We found effective systems in place that encouraged staff engagement.
There were effective systems in place to deal with comments and complaints, including providing patients with information about how to raise concerns or make a complaint.

Critical care **Not sufficient evidence to rate** 

It is important to point out that this section of the report relates to staff input rather than patient outcomes. There were no patients in the unit at the time of the

inspection, so it is not possible to give a rating based on the care patients received. The inspection report is a narrative rather than a judgement against the ratings.
Overall we found that there were significant concerns identified by the inspection team. The concerns identified included staffing levels, the results of local audits and the potential for the reduction of nurse competencies due to lack of practice.
The CCU was empty during our inspection. Nursing staff were engaged with writing new policies and protocols in preparation for a future increase in patients and therefore failed to routinely practice critical competencies and skills. This lack of practice put staff at risk of losing critical competencies and skills. Although there was a programme in place to mitigate such losses – including the opportunity for staff to work supernumerary shifts in CCUs at other hospitals – we found that its processes were not structured or consistent enough for staff to be sure that their skills were maintained.
The CCU environment was clean, hygienic and well equipped. New equipment was in place and staff had been trained in its use. The lead nurse maintained documentary evidence that staff were adequately trained and assessed in the use of equipment.
A change in nursing staff rotas meant that the CCU could not accept emergency or unplanned admissions. A non-contractual system of flexible working was in place among the nursing staff that meant they were often under pressure to work excessively long hours. Consultant intensivists were available on a 24-hour rota, which sometimes breached Intensive Care Society (ICS) requirements as staff would also be on call for another hospital at the same time. Staff told us that the provision of adequate staffing levels was

Summary of findings

one of their main concerns about the service and the unit could not safely be opened for non-elective patients until more nurses were recruited.
An incident reporting procedure was in place and most incidents relating to the CCU occurred due to low staffing levels. Incident reports monitored by senior management contained inconsistent evidence that learning from incidents had taken place.
Experienced staff were in the process of establishing policies and protocols using national benchmarks and standards, including clinical guidance from the National Institute for Health and Care Excellence (NICE) and the British Association of Critical Care Nurses (BACCN). The CCU was not contributing to national audits compiled by the Intensive Care National Audit and Research Centre (ICNARC) as the department was operating at a low capacity. Staff had begun to conduct small internal audits as preparation for future national versions.
Staff were passionate about building the capacity of the service and planning for its future success as a centre of excellence. The acting lead nurse for the department had undertaken work to ensure the team was robust, stable and coherent and a recruitment plan had been implemented to increase staffing levels and so accommodate greater capacity. The department was short of three full time nurses to meet the number considered safe for it to operate at full capacity.

Services for children and young people

Good

This report relates to an entirely outpatient based service and the ratings and narrative reflect this.
We rated services for children and young people as Good overall. We rated services as good for being safe, responsive, caring and well led. We rated effective the domain as requiring improvement.

Summary of findings

Children were seen in a bright, clean, purpose built, child friendly environment which had modern equipment and age appropriate facilities. Children were chaperoned throughout the outpatient department by appropriately trained children's nurses. All nurses within the hospital had received level two safeguarding training and those in direct contact with children had completed level three training. Care was being provided by competent, well trained staff in all areas inspected.

The parents we talked to spoke very highly of the service and care their children had received at KIMS hospital. There was good access and flow to children's services and increasing numbers of children were being seen. The hospital had employed a second children's trained nurse to cope with the increase in demand.

The leadership of the hospital was cohesive, transparent and visible to all staff members. The service had an open culture where incident reporting was actively encouraged and used for training to improve care. Staff and public engagement were sought via satisfaction surveys for staff, parents and children. However the leadership of the children's service lacked some key roles. There was a lack of senior oversight of the service from a paediatric or children's nursing perspective and whilst this did not impact significantly on the outpatient service offered, it did leave the service operating outside of national guidance for the care of children in the independent sector and safeguarding children.

Outpatients and diagnostic imaging

Requires improvement

We rated the outpatient department as required improvement. We identified problems with the safety and leadership of the service.

Not all staff reported safety incidents and there was inconsistency with learning from incidents. One type of medicine was not

Summary of findings

stored as the instructions on the label advised. Patients received some medicines without complete instructions, which did not comply with best practice guidelines. There was no legal framework in place for a member of staff to give out medicine. An unregistered health professional held keys to the medicines cupboard. The outpatient manager did not know there needed to be a legal framework in order for nursing staff to administer medicines.

The premises were not compliant with national guidance on nfection prevention and control measures. There were carpets fitted in clinical areas where procedures were undertaken. Not all staff complied with the Bare Below the Elbows initiative. Storage of some patient records did not meet the standards of the Data Protection Act. Floor surfaces did not meet building standards for a clinical environment.

Staff treated patients with kindness, dignity, respect and behaved in a professional manner. We saw processes that enabled patients individual needs to be met.

Some staff in outpatients did not follow best practise guidelines because they lacked knowledge to do so. However, the radiology department demonstrated clear knowledge of best practise and processes to measure this.

The outpatient clinic ran clinics during weekdays, evenings and at weekends. There was some variability in the recorded waiting times for NHS and private patients, because of the availability of consultants and patient choice. The radiology department provided flexibility with staff to support theatre services.

Despite extended hours for outpatient clinics and a low throughput of patients attending, there was a high number of cancelled appointments, including short notice cancellations.

There was a lack of data collection to inform service planning.

Summary of findings

In outpatients staff did not always feel part of a team and some staff told us they felt isolated. There were not clear processes in place to always keep patients from harm. It was recognised by the inspection team that the radiology department were providing a very good level of service and care to their patients. Staff in radiology felt part of a team and involved. In this department there were clear processes in place to keep patients from harm.

Requires improvement

Kent Institute of Medicine and Surgery (KIMS)

Detailed findings

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

Detailed findings

Contents

Background to Kent Institute of Medicine and Surgery (KIMS)

KIMS Hospital is an independent acute hospital run by KIMS Hospital Ltd. It provides care and treatment for private (self-funded and insured) and NHS patients referred under the Standard NHS Acute Contract. The hospital is located on the outskirts of Maidstone and close to the M20, providing easy access for people travelling from other areas of Kent. The hospital is newly built and first opened to admissions in April 2014. The hospital has 81 overnight inpatient beds and 20 day care beds.

We inspected five core services including surgery, medicine, outpatients and diagnostic services, critical care and services for children and young people. We also looked at the overall leadership of the service. The hospital did not provide maternity services, termination of pregnancy or emergency care. We did review how end of life care was provided at KIMS but have reported this under the medicine core service report as there were so few patients receiving end of life care at the hospital.

Our inspection team

Our inspection team was led by:

Inspection Manager: Terri Salt, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a Director of Nursing, a clinical governance manager, three consultant surgeons, a palliative medicine consultant, a Director of Nursing from a children's hospital, a physiotherapist, an occupational therapist, a critical care consultant, clinical nurse specialists for end of life care, critical care, surgery and oncology, a ward manager, a safeguarding lead nurse, a medical director, an infection prevention and control specialist, an expert by experience and a pharmacist.

How we carried out this inspection

Prior to the inspection we reviewed information we held about this provider.

The provider was asked to submit additional information and this was reviewed by our analysts and inspectors.

We asked key stakeholders for their views on the service.

Detailed findings

We visited the site on 23 and 24 September 2015 to make an announced inspection. We followed this up with an unannounced inspection on 29 September 2015.

Whilst on site we spoke with staff of all grades and professional disciplines and spent time observing care on the wards and in the operating theatre. We spoke with patients and their relatives about the care and treatment they had received.

We interviewed managers and key staff about the way they were providing services.

We reviewed a large number of individual patient records because we need to understand how treatment for specific conditions was managed and there were insufficient patients in the hospital at the time of the inspection to allow for this without a notes review.

We reviewed records maintained by the provider.

Facts and data about Kent Institute of Medicine and Surgery (KIMS)

Kent Institute of Medicine and Surgery started as an idea 10 years ago amongst a group of clinicians. After a lengthy gestation while achieving financing and planning consent, work to build KIMS started in 2012 with completion in early 2014. It opened as a hospital in April 2014. Although a very young organisation, the hospital has developed rapidly since. It has more than 250 consultants working with practising privileges.

The hospital offers all the standard adult secondary care elective surgical procedures and offers a medical admissions service. There is also an established critical care service providing high dependency and intensive care and the hospital has started to develop tertiary care services, in particular complex cardiology procedures and cardiac surgery.

There were 2,486 visits to theatre between April 2014 and March 2015. The five most common procedures performed were:

- Facet joint injection (under X-ray control) - 5 to 6 joints (148)
- Phacoemulsification of lens with implant - unilateral (144)
- Coronary angiography as sole procedure (132)
- Total prosthetic replacement of knee joint, with or without cement, +/- patella (92)
- Multiple arthroscopic operation on knee (including meniscectomy, chondroplasty, drilling or microfracture (73).

Kent Institute of Medicine and Surgery has not been inspected previously.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Inadequate	Not rated	Good	Good	Requires improvement	Requires improvement
Critical care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Services for children and young people	Good	Not rated	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Notes

Requires improvement

Are services safe?

Our findings

Overall we judged that the safety of services required improvement.

Key issues that supported this judgement included staff who were unclear about their responsibilities in relation to the Duty of Candour. Some training had been provided but this had not proved effective for the majority of staff.

The organisational learning from incidents was not robust enough. The dissemination of learning was very localised; opportunities for wider learning were missed.

Governance systems were not robust enough. The arrangements for monitoring of consultant practice were inadequate. The Medical Advisory Group was not provided with the information about individual consultant's practice and this meant they could not carry out their role effectively.

The underutilisation of the hospital posed a risk that staff would lose their skills. This was a particular risk in critical care and where complex surgery was undertaken at the hospital.

A lack of clarity about which procedures and treatments could be offered from KIMS hospital posed a risk that a consultant might perform an operation which other staff were unfamiliar with and for which the service was not properly resourced. Conversely, the high number of consultants offered practising privileges meant there was a risk of a consultant providing treatment in a setting they were unfamiliar with.

Not all specialities provided formal multidisciplinary review of their patients. We found examples where it could not be demonstrated that there had been proper follow up for patients.

The oversight of the endoscopy service was inadequate. The facilities were poor and the reversal agents were not readily available to recovering patients. There was no senior manager responsible for this service.

Mandatory training rates were very good.

Staffing levels were generally good but the arrangements for staffing of the critical care unit posed a risk to patients.

Safeguarding arrangements were adequate.

Medicines management was generally good.

Good

Are services effective?

Our findings

We judged that the effectiveness of services provided by KIMS hospital was good.

Staff followed national guidelines and patients were generally treated in accordance with best practice guidelines. The exception is where women with suspected breast cancer are provided with treatment outside of a dedicated one-stop clinic.

People reported that their pain was well managed.

Risk assessments were used to inform care planning for all admitted patients. This included VTE assessment, pressure damage risk assessment, malnutrition risk assessment and a mobility risk assessment.

Food was said to be good and there was access to specialist dietician's advice where necessary.

Staff were competent although the low usage posed a risk to this, the provider had taken some measures to mitigate against the risk in the short term.

Consent prior to surgery was well documented. Staff working with children understood the Frazer guidelines for consent by a competent child or young person.

Good

Are services caring?

Our findings

People we spoke with were all very positive about staff attitudes and behaviours. They reported nursing staff as kind and helpful.

We observed compassionate care and kindness throughout our visit. Staff smiled at everyone, including other staff.

There was a nice feeling as you walked around the building. Doors were always held open and staff offered assistance with directions to the inspection team, visitors and patients. Reception staff greeted everyone warmly and often walked them to where they needed to be.

We could not rate caring on critical care as we could not gather sufficient evidence.

Good

Are services responsive?

Our findings

We rated the responsiveness of services at KIMS hospital as 'Good'.

In general, peoples' individual needs were well met by the staff.

Service planning was in transition with a new CEO implementing a change in focus and service delivery to make the hospital more sustainable. The very low occupancy rates meant service planning was difficult in specialist areas such as critical care which operated on an ad hoc basis.

The hospital had access to a telephone translation service but not all staff were aware of this. There were times when a translator should have been used (such as when seeking consent) but the service had not been provided.

The policies for end of life care had not been ratified and there was little guidance available to staff on how best to meet someone's needs as they approached the end of life. There was no system for identifying patients who were requiring end of life care. Links with local palliative care providers had not been developed. There was no rapid discharge policy for patients approaching the end of their life. This meant people could not be transferred to their preferred place of care and death in a timely manner.

Learning from complaints and concerns was limited. Some complaints were logged as incidents rather than complaints. Informal complaints were not logged or monitored at all. This was a missed opportunity for learning.

There were no problems with access and flow. Patients could be referred via their GP, another consultant or could self refer. Appointments were offered at a time of the patient's choosing. The time from the initial referral or contact to consultation and treatment was short. People were seen quickly.

Dementia care was not well developed but the service had not had to care for many people who lacked capacity. Staff understood the concept of mental capacity well and were able to describe how they would adapt the care they provided to meet the needs of someone with dementia. This is an area the hospital will need to develop as it expands and accepts more elderly people.

Requires improvement

Are services well-led?

Our findings

Overall we rated the 'well led' domain as Requires improvement.

The vision for the service was not well understood by all staff. The hospital was in a period of transition following the appointment of a new CEO and services offered were likely to change as a result of this.

The assurance framework was insufficiently robust and opportunities for organisational wide learning were missed. The provider recognised this and a new Governance manager had been appointed but had not been in post a sufficient time to be able to demonstrate and impact.

The clinical leadership of specific services was not sufficiently developed. This included a lack of senior clinical oversight with expertise in end of life care, infection prevention and control, critical care nursing and children's services.

The Board were actively involved in the oversight of the hospital and reviewed both financial and clinical performance.

The board had received training on their responsibilities as a board member, including Fit and Proper Person (FPP) training.

Staff reported positively on the organisational culture. They said local managers were approachable and fair. Staff felt they could raise concerns and be listened to.

Medical care

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

Information about the service

The Kent Institute of Medicine and Surgery (KIMS) is a private hospital that opened in April 2014 and provides care for both private and NHS funded patients. KIMS can accommodate 101 inpatient and day care patients. However, at the time of the inspection just one inpatient ward with 17 beds was in use for both medical and surgical patients, of which there were three medical patients at the time of the inspection visit. In addition there is an Endoscopy Unit and an Interventional Suite with two Catheterisation Laboratories. The service offered a range of medical procedures, treatment and diagnostics with an emphasis on cardiology.

We visited Nickleby Ward, the Interventional Suite and the Endoscopy Unit. We reviewed a large amount of performance data as well as commentary from the public and external stakeholders. We spoke with three patients and two relatives as well as 17 members of staff. We also reviewed patient records and other documents during the inspection.

The findings for End of Life Care have been included in the medicine core service as the cohort of patients who had required end of life care was so small.

Summary of findings

The leadership of medical services at KIMS was lacking expertise in end of life care and oversight of the endoscopy suite. There was no clear vision for medical services, which were slotted in amongst the elective surgical patients. There were missed opportunities to develop high quality services during the set up stage of the hospital when the service had significant capacity to do so. There had been a 'take all' attitude to admissions rather than a carefully planned staging of the care provision that ensured the service only admitted those patients whose needs could be fully met.

The oversight of incidents and a culture of learning from mistakes was not was not embedded. Poor governance arrangements failed to ensure any lessons learned were disseminated across the organisation.

We identified concerns with the Endoscopy Unit that included a lack of medicine checks, inability to access reversal drugs promptly, inappropriate storage of hazardous substance and recovery room that was not fit for purpose.

Staff demonstrated knowledge and understanding of the incident reporting process and we found evidence of action and learning. However, themes and trends were not collated at organisational level. There were processes in place to ensure safe staffing levels. The hospital was managing the use of agency staff to improve continuity. Staff had access to good quality equipment.

Medical care

We found some policies that were out of date or required updating. There were systems in place to take account of published research and national guidance. There was also an audit programme in place but not embedded due to low numbers of patients. We found varied understanding of mental capacity assessments.

We have reported end of life care services under the medicine core service as there was insufficient evidence to rate it separately. We have considered the findings for end of life care in a proportionate manner so that comments made about shortfalls in the narrative of this section are put into the context of the very few patients who received end of life care in determining the rating.

End of life care services were not sufficiently developed to ensure that the staff could meet the needs of dying patients. There was, in effect, no end of life care service but the hospital had admitted a few patients who were in need of end of life care.

Pain was well managed. There was a good process in place for gathering patient feedback with action taken. Staff could access training and development. There were good processes for induction of new permanent and agency staff. Staff demonstrated good team and multidisciplinary working.

Patients and their relatives were very positive about their care during their hospital stay. Patients described how staff were professional and knowledgeable and supported them in a compassionate and caring manner. Staff protected patients' privacy and dignity and treated each patient as an individual.

Staff felt involved in the vision for the hospital and were happy to be working at KIMS. They described an open culture with good up and down communication. Staff felt able to express their ideas for improvement.

We found no evidence of mortality and morbidity meetings. Record keeping was varied. There was carpeting in the bedrooms that did not comply with Department of Health building note in respect of infection control.

Are medical care services safe?

Requires improvement

We rated the medical care services as requires improvement because:

There were missed opportunities for learning from incidents. Although staff reported incidents there was not a robust procedure to ensure any trends or themes were identified. There was no evidence that morbidity and mortality meetings were in place.

All the bedrooms were carpeted. This did not comply with the Department of Health, Health Building Note that states carpets should not be used as this area has a high probability of body fluid contamination. There were no hand sanitisers outside or immediately inside the bedrooms however, patients told us they had observed staff using the hand sanitisers regularly as well as washing their hands. All the bathrooms as well as the bed rooms had call bells which were included on the room checklist.

The cupboards storing medicines in the procedure room was not locked. Formalin was also stored there which was not appropriate.

The hospital did not have a major incident plan. This meant there were no arrangements in place for dealing with unforeseeable emergencies. Staff were unable to describe their role should a major incident occur.

We saw that a selection of the daily, weekly and monthly environment and equipment checklists were completed. Where action was required it was recorded when completed and signed off and closed. All the bathrooms as well as the bed rooms had call bells.

Staff demonstrated knowledge and understanding of safeguarding and could describe types of abuse. They were able to access safeguarding policies and procedures and knew who the hospital safeguarding lead was.

Incidents

- During the period April 2014 to March 2015, there were no reported never events, serious injuries or incidents of Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C.diff) or Methicillin Susceptible Staphylococcus Aureus (MSSA) reported.

Medical care

- There were 22 incidents reported in respect of medical patients over the last 12 months. 73% were split between medicine administration errors and prescribing errors. We were informed that no root cause analysis was carried out for any of these incidents.
- We saw that incidents were reported by the Catheterisation Laboratory staff into the hospital system as well as, where appropriate, to the Radiation Protection Supervisor.
- At an organisational level, trends and themes were not being collated which meant that opportunities for learning could be missed.
- Staff we spoke with demonstrated knowledge and understanding of the incident reporting system. Incidents were being consistently reported, however this was a paper based system which made analysis of the data difficult.
- Staff said they received feedback on relevant incidents, together with learning outcomes. One example of action following a patient fall on the ward was that patients at risk of falling should be located near to the nurse station and we saw that this was in place at the inspection visit.
- There were a total of 15 falls over the last 12 months but it was not possible to identify the numbers that could relate to medical patients as both surgical and medical patients were cared for on Nickleby Ward.
- One member of staff described a recent discussion with a patient under Duty of Candour and the completion of the relevant documentation.
- There was no evidence that morbidity and mortality meetings were in place. These meetings are peer reviews of complex patients or where there may have been concerns over the clinical care and lead to improved services. Patients that die are discussed to ensure the death was expected and not caused by poor clinical practices.

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

- Safety thermometer data was being collected. However, the data was not being displayed in public areas as expected. This meant that patients and staff did not have easy access to data that demonstrated a harm free care environment.

Cleanliness, infection control and hygiene

- The hospital undertook an infection prevention and control audit in September 2014. The audit excluded theatres, kitchens, closed wards and sterile services department. The report identified areas for improvement such as dust in some areas and some open storage in the pantry on Nickleby Ward.
- We were told that there had been some building maintenance at the time. At our inspection we observed that Nickleby Ward was visibly clean and tidy and an improvement on the September 2014 audit.
- Hand sanitisers were available by the nurse station on the ward. However, hand sanitisers were not available either outside each single room or immediately inside the rooms. This would facilitate staff hand hygiene in line with guidance such as the World Health Organisation “Five moments for hand hygiene”.
- We saw hand washing posters in clinical and non-clinical areas. Staff we spoke with demonstrated knowledge of the importance of good hand hygiene.
- We saw patient information leaflets on infection prevention and control in waiting areas.
- Patients and relatives we spoke with told us the hospital was very clean. They had observed staff using the hand sanitisers regularly as well as washing their hands.
- Personal protective equipment such as disposable aprons and gloves were easily accessible for staff. We observed staff wearing them when delivering personal care.
- The hospital used green ‘I am clean’ stickers for general equipment such as blood pressure devices and intravenous (IV) stands.
- The sharps bins were not overfilled and were labelled and dated correctly.
- There was a “last offices” box in the ward area. The box included a flow chart to guide staff as to how to prepare a body for removal by the undertaker. It also contained an infection control certificate to be used for the deceased. The staff knew and could explain the procedures.

Environment and equipment

- There was only one ward accommodating medical patients at the inspection visit. The ward had 17 en-suite single rooms of which the first four contained monitors for cardiology patients.
- All the bathrooms as well as the bed rooms had call bells. We saw examples of completed room check lists that included call bells and monitors.
- All the bedrooms were carpeted. This did not comply with the Department of Health, Health Building Note

(HBN) 00-09: Infection control in the built environment hospital building note (3.82) that states carpets should not be used as this area has a high probability of body fluid contamination.

- The store room containing medical supplies and equipment required card entry in line with best practice.
- There was Cardiac Catheterisation Laboratory in use at the time of the inspection with another available for when throughput increased. These were equipped to a high standard. Cardiac Catheterisation Laboratories are examination rooms in a hospital or clinic with diagnostic imaging equipment. The equipment is used to visualise the arteries of the heart and the chambers of the heart and treat any stenosis or abnormality found.
- The equipment in the Cardiac Catheterisation Laboratory was all checked and calibrated in preparation for the clinical list. Cardiology equipment, e.g. electrophysiological study equipment, was checked and prepared by the physiologist. One consultant we spoke with stated that this was a very efficient service.
- We saw that a selection of the daily, weekly and monthly environment and equipment checklists were completed. Where action was required it was recorded when completed and signed off as closed.
- There was an Endoscopy Unit that consisted of two procedure rooms, one of which was decommissioned and being used as the recovery area for patients post procedure. This room was not fit for purpose as it was cluttered with tools and other items that made access to the patient difficult in the event of an emergency.
- We saw that checks were in place for the endoscopy equipment in the procedure room.
- We saw examples of the daily tests for the sterilisation equipment that ensured all the scopes were properly decontaminated so that there was no possibility of cross contamination. All sterilised equipment was dated and reprocessed if not used within the time period.
- All rooms in the hospital were single rooms with en-suite bathrooms which helped maintain the privacy and dignity of people receiving end of life care and their families.
- There was no mortuary at the hospital. A local family undertaker provided mortuary services under a service level agreement. We did not inspect the undertaker's mortuary as part of our inspection.
- There were facilities for relatives to stay overnight, if the patient wished this.

Medicines

- Ward medicine trolleys were of an adequate size.
- Controlled drugs (CD's) were ordered, stored and returned to pharmacy in accordance with guidance. They were tracked and signed out by two members of staff at all times. The records seen showed us that staff were checking the stock levels in line with the hospital policy. Controlled drugs were also managed in accordance with best practice in the Endoscopy Suite.
- Fridge temperatures were recorded daily in line with best practice.
- Medication was administered at the prescribed time. This was reflected on the Medication Administration Records that we reviewed and in conversation with patients.
- Antibiotic prescribing was being closely monitored by the pharmacy team to ensure best practice in the use of antibiotics was being followed.
- Staff were required to undertake a competency based assessment before they were allowed to administer medicines.
- The service had segregated stores for empty and full medical gas cylinders which followed national recommendations.
- Medicines were stored in the procedure room in the Endoscopy Unit. Patients recovered in the decommissioned room a few yards away. This meant that access to reversal agents (these reverse the effects of anaesthesia and sedation) such as Flumazenil and Naloxone was restricted as there would be a sedated patient in the procedure room.
- In addition, the Naloxone expired in August 2015. This indicated that medicine checks were not in place.
- The cupboards storing medicines in the procedure room was not locked. Formalin was also stored there which was not appropriate. Formalin is covered by the Control of Substances Hazardous to Health (COSHH) regulations. There was a COSHH compliant labelled and locked cupboard in another room. We were told that the Formalin was in the procedure room for ease of use.
- We were told that there was no IV or oral chemotherapy carried out at KIMS hospital at the time of the inspection, although one patient had completed treatment in August 2015. We therefore did not inspect this part of the service. We advised the hospital that their web site advertises intrathecal chemotherapy. The

hospital was not properly resourced to provide intravenous chemotherapy and had not got the protocols in place to minimise side effects and cope with potential complications.
- There were no guidelines or ratified policy for the prescription of medicines to patients at the end of their lives. This put people at risk of receiving inappropriate medicines or doses.
- We reviewed the medicine administration records (MAR) of the three patients whose notes we reviewed. We found one end of life patient's MAR chart did not include any anticipatory medication for nausea or pain relief. This put the patient at risk of experiencing a delay in receiving appropriate medication

Records

- Patient medical records were stored securely to maintain confidentiality.
- As there were few medical patients on the ward at the time of the inspection, the hospital provided a selection of records for patients who had been discharged.
- We looked at five records for discharged patients and three for current patients on the ward.
- We found varied quality of record keeping. For patients discharged we found a lack of either mental capacity assessments or evidence of discussions with patients regarding their plan of care. We found omissions in record keeping such as incomplete National Early Warning Score (NEWS) charts and some risk assessments were not completed.
- There were several areas of poor record keeping in one set of records for a patient discharged in May 2015. These included blood pressure readings between the hours of 03:15 and 10:15 that showed the pressure had dropped significantly but there was no NEWS score completed until 11:30. This meant the patient was not escalated appropriately. The NEWS chart was incomplete and in parts illegible. No weights were recorded. The Venous Thromboembolisation (VTE) chart was incomplete although prophylaxis was prescribed. The nutrition score was incomplete from 20/05/15 to 23/05/15. On the medicines record a sticker was used that included two different medicines with different dosages. The medicine prescribed should be clearly identified on the sticker but this was not completed. This meant that the patient could have had the wrong dose administered.
- We found some varied practice in the current records. However we saw risk assessments completed, good completion of NEWS charts and good recording of care and treatment provided.
- We saw pathway documentation for patients undergoing procedures such as cardiac angiogram and cardiac device pathway.
- Consultant Practicing Privileges agreement included that patient records must not leave the hospital without permission. These would be granted by exception or in an emergency. Additional tracking processes were in place should that occur.

Safeguarding

- The Director of Clinical Services was the safeguarding lead for the hospital.
- Staff we spoke with, nursing and medical, described safeguarding training as part of their mandatory training. We were told that safeguarding was part of staff induction with biannual e-learning updates. We saw safeguarding training on the ward training matrix we looked at. The training covered children and vulnerable adults. Staff demonstrated knowledge and understanding of safeguarding and could describe types of abuse. They were able to access safeguarding policies and procedures and knew who the hospital safeguarding lead was.
- Safeguarding training compliance rates could not be separated for medical care as staff cared for surgical patients as well on the ward currently in use. We saw evidence on the ward that all staff had undertaken the training.
- Staff we spoke with said that, to their knowledge, no safeguarding concerns had been raised since the hospital opened. They would escalate any concern to senior nursing staff. No safeguarding concerns had been reported in the last 12 months.
- We saw laminated posters at the nurse stations on the wards that provided safeguarding information and local authority contact numbers.
- We also saw patient information regarding preventing a fall during their hospital stay.

Mandatory training

- We saw the training matrix for staff on Nickleby Ward that showed all staff were up to date for training such as moving and handling and fire safety. The matrix identified that additional training had recently been

introduced for: infection prevention and control; health, safety and welfare; equality and diversity, and paediatric immediate life support (PILS). We saw that staff were booked on to modules and that this was monitored.

- The staff told us that they had a training passport that was held centrally by the human resources department. These were signed off when the training was completed. Staff said they received email reminders when training was due to be updated. We saw personnel records that confirmed the use of training passports.
- Staff we spoke with gave examples of mandatory training that included basic life support and immediate life support, blood transfusion and syringe pumps.
- Mandatory training compliance rates could not be separated for medical care as staff cared for surgical patients as well on the ward currently in use. Levels of completion of mandatory training ran at over 98% with shortfalls being due to new starters or longer term absence.
- We saw an example of a resident medical officer's (RMO) continuous professional development. This demonstrated up to date training in, for example, fire safety, infection control, lone worker, safeguarding and complaint handling.

Assessing and responding to patient risk

- The hospital used the National Early Warning Score (NEWS) system to identify and escalate care of any deteriorating patients.
- Where a patient was identified as deteriorating by nursing staff they escalated the concerns to the RMO who reviewed the patient to ensure appropriate changes in treatment plans were made. Consultants were contactable and available.
- The staff said that the hospital could open critical care although this was not actually the case and people who became seriously unwell needed to be transferred to and NHS hospital via a 999 call to the emergency services.
- Staff we spoke with felt that deteriorating patients were well managed. However, one set of medical records we looked at showed that the patient had not been escalated in accordance with the NEWS score.
- In the Endoscopy Unit NEWS scoring post procedure was not in place. This meant that a deteriorating patient may not be identified. We were told that patients stayed in recovery 10 – 15 minutes with observations every five minutes.
- Emergency equipment was located more than 100 yards from the Unit and was not easily found when we asked staff where it was.
- There were systems in place for patient transfer, both internally and externally, via consultant to consultant referral. We saw there were service level agreements in place with NHS hospitals with all contact numbers available. We saw confirmation that the system was within the existing ambulance contract. There were flow charts for all conditions, for example emergency surgery, with transfer forms, checklist that travels with the patient.

Nursing staffing

- Staff we spoke with felt that staffing levels were adequate for current inpatient numbers. They told us that any shortfalls or additional skill requirements would be met by the use of bank and agency staff.
- Nickleby Ward could accommodate 17 patients. The usual establishment was three registered and two non-registered nurses for the early and late shifts with two registered nurses on at night, at least one of which was a sister.
- On 23 September 2015 there were 16 patients on the ward. Staffing was three registered nurses plus the ward manager who was supernumerary. There was one non-registered nurse who was there delivering 1:1 care of a patient living with dementia. Ideally there would have been another non-registered nurse.
- However, we saw evidence from a random sample of duty rosters that in the great majority of cases the establishment was met. The ward was fully staffed on the day of the unannounced visit.
- Staff were expected to be flexible and either come in or be stood down at 24 – 48 hours' notice. The hospital had very recently introduced a four day booking route that enabled off duty to be looked at earlier and give staff a bit more notice.
- The hospital used staff from a variety of agencies. We were told that the organisation was looking to block book agency staff for a month at a time to improve continuity of care. This demonstrated that the provider was aware of the potential risk to patient care when using high numbers of different agency staff. We saw evidence that this was in place on Nickleby Ward for the month of October at the unannounced visit on 7 October 2015.

Medical care

- We attended a daily planning meeting. These were held at 11am with representation from each department. The meetings included reviewing patient and staff numbers. The whiteboard in the room was updated to accurately reflect activity and staffing numbers. Minutes were not kept of the meetings.
- In addition there was a weekly meeting held each Friday. The purpose included planning resources for the following week, including any staffing concerns.
- We saw the electrocardiogram competency assessment form and examples where it had been signed off for staff on the ward.
- We were told that refresher courses were planned for medication competency assessment. The hospital had linked up with a nearby NHS hospital for a training course in IV fluids, venepuncture and cannulation starting in December 2015.
- Cardiac catheterisation competencies were all reviewed on the ward. There was pre-assessment induction. The nurse competency programme included, for example, coronary angioplasty and intra-aortic balloon pump.
- There were nurse competencies for ward based staff. There were interventional suite competencies such as the scrubbing role and the running role. We saw a completed and signed off on 21/09/2015 Local Agency Induction programme. We saw the comprehensive induction pack for new staff that takes up to one year to complete.
- There were three trained nursing staff in the Cath Labs.
- There was one whole time and four part time physiologists who set up the cardiology equipment in the Cath Labs, working closely with the nursing staff.
- The staffing for endoscopy lists was one qualified technician in the procedure room, one qualified in the recovery room and one non-registered nurse in support.

Medical staffing

- There were two RMOs on duty at all times. The critical care RMO also took responsibility for all medical inpatients 24 hours a day.
- Daily handovers between one RMO and another were in place. If there was a specific concern about a patient then the designated consultant was responsible for handing over to the RMO on duty.
- There was 24 hour consultant led care. This system operated via an on-call basis and we saw the on-call rota for consultants. Each consultant took responsibility for their own patients but if, for some reason, they could not be contacted then the on call consultant attended.
- There was a formal 'buddying' system in place for when consultants were absent, for example on annual leave.
- There were no specialist palliative care consultants with practicing privileges at the hospital at the time of our inspection.
- The matron was in discussion with a palliative care consultant who was in the process of applying for practicing privileges. The hospital planned to work with this consultant as their lead clinician for end of life care and to develop the service in collaboration with him.
- The RMO we spoke with had no specific training or experience in caring for patients at the end of their lives.

Major incident awareness and training

- The hospital did not have a major incident plan. This meant there were no arrangements in place for dealing with unforeseeable emergencies.
- Staff were unable to describe a major incident and were not aware of their role should a major incident occur. Staff stated that in the event of a fire they would call 999 and the nurse in charge would take control.

Are medical care services effective?

Good

We found some policies that were out of date or required updating. There were systems in place to take account of published research and national guidance. There was also an audit programme in place but not embedded due to low numbers of patients. We found varied understanding of mental capacity assessments.

Pain was well managed. There was a good process in place for gathering patient feedback with action taken. Staff could access training and development. There were good processes for induction of new permanent and agency staff. Staff demonstrated good team and multidisciplinary working.

This section of the report details significant shortcomings in the end of life care provision for patients admitted to KIMS. It has not adversely affected the rating as the number

of patients admitted for end of life care was so small. The hospital did not have the resources in place to identify and manage patients who needed end of life care. It is the view of the Commission that patients requiring palliative care should not be admitted until the provision to meet their needs has been developed fully.

The hospital had not finalised the policies and procedures for the care of patients at the end of their lives. Despite this they started the process to publish them.

Managers were aware of relevant published guidelines but these were not readily available Patients receiving end of life care were not routinely referred to palliative care specialists because the policies and procedures had not been implemented.

Staff had not received specific training in caring for patients at the end of their lives.

There were no guidelines for prescribing drugs to control common symptoms experienced as people approached the end of their life. There was no system for ensuring people were prescribed anticipatory medication so that symptoms could be treated in a timely manner if they did occur.

The very limited of number of patients admitted for end of life care meant staff were not using the skills necessary to identify patients approaching the end of life and provide good palliative medicine and care for them.

Improvement was needed in the way that Do Not Attempt Cardiopulmonary Resuscitation forms (DNACPR) were used. The small number of times the process was used showed failings to assess capacity effectively and prolonged consultation. The low number of patients receiving end of life care at KIMS meant staff were less familiar with the national guidance and local policy for the use of DNACPR forms.

Evidence-based care and treatment

- We found systems in place that demonstrated the service took account of published research and national guidance.
- We found the recommendations from National Institute for Health and Care Excellence Clinical Guideline 83 (NICE CG 83) on critical care follow-up and rehabilitation were being implemented to develop a robust rehabilitation service for patients. Care was provided in line with NICE CG50 (Acutely ill patients in hospital).
- The hospital policies were based on NICE and Royal College guidelines. The policies were available on the hospital intranet as well as paper copies on the ward.
- Staff had to confirm they had read the policies by providing a signature and date on the day they were updated. The list we reviewed was not always complete so this meant that there was no guarantee that staff were aware of specific policies. We reviewed a list of 62 policies, 19 were approved and 25 were missing.
- We also identified policies that had expired and required updating, for example the management of Clostridium difficile (C.diff) and Care of Patients with or at risk of Creutzfeidt-Jacob Disease (CJD) or VCJD.
- Policies we looked at in the Cardiac Catherisation Suite were up to date. We saw the policy folder in respect of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) together with Local Rules and Standard Operating Procedures.
- Joint Advisory Group (JAG) accreditation for the Endoscopy Unit had not been applied for as it was felt by the provider that the Unit would not meet the requirements.
- There was no policy for end of life care in the hospital. We were shown a draft policy which had been drawn up with reference to current published guidance including the Gold Standards Framework (GSF), a national initiative to deliver high quality care to people with advanced disease. However, the policy was not ratified or available to staff.
- The draft policy referred to an end of life care “plan” that should be in place for all end of life patients. There was a draft end of life care “pathway” which had been drawn up with reference to recent publication from the Leadership Alliance for the Care of Dying People but this was not yet finalised and in place.
- Following an independent review the Liverpool Care Pathway was discontinued across England by July 2014. The pathway was associated with poor experiences of care because of a lack of tailored, personalised care. Since this review, providers should put in place care “plans” for dying people and not care “pathways”. However, the draft hospital documentation referred to care “pathways”.
- Neither the draft policy nor the draft care pathway made any reference to NICE guidelines (NICE QS13 End of Life Care for Adults) although these had been discussed at a recent end of life care planning meeting. This was recorded in the minutes of the meeting, which we saw.

- There was no policy for the care of the deceased in the hospital although there was a "last offices" box which included guidance for staff on dealing with deceased patients.
- The provider had not participated in the National Care of the Dying audit at the time of our inspection.
- None of the patients who received end of life care at the hospital had been referred to a palliative care specialist.

Pain relief

- Patients we spoke with told us that their pain was well managed. Staff regularly checked with them regarding pain and there was a range of pain relief that was provided promptly.
- There was a patient information leaflet available on over the counter pain relief.
- The hospital provided patient satisfaction data to an external company for benchmarking against 90 other hospitals. KIMS came second out of the 91 hospitals in respect of patient satisfaction with pain management in the last report dated August 2015.
- However, we did find that pain scores were not recorded in three of the patient records we looked at.
- The hospital held a Home Office license for controlled drugs, which meant that end of life care patients could have access to controlled drugs for pain relief should they require them.
- Of the three records we reviewed, two patients had no anticipatory pain relieving medication prescribed and one person had these medicines prescribed but the dosages and routes of administration were not appropriate. This put patients at risk of experiencing a delay in receiving medication, or of receiving an inappropriate dosage of medication.
- There were no syringe pumps available at the hospital to provide end of life care patients with continuous pain relief. Staff told us that none of the patients who had received end of life care at the hospital needed to use a syringe pump. In our review of patients' records we saw no evidence that patients had required pain relief via a syringe pump.
- Staff said that they would arrange to borrow syringe pumps from the local trust if they required them, although there were no formal arrangements in place for this.

Nutrition and hydration

- The catering service was contracted to an external company.
- We saw that in the pantry on the ward there was a whiteboard that highlighted such things as allergies for individual patients. This meant that the external company staff had accurate information regarding nutrition for each patient.
- Patients had a nutritional assessment on admission, however we found incomplete nutrition scores in two of the patient records we looked at.
- Patients described the food as very good with choice and consideration to the required portion sizes all taken into account.
- We saw good evidence in the records we reviewed of assessment of patients' nutrition and hydration needs as they approached the end of their lives. These were included in their individual care pathways.

Patient outcomes

- We were told that 99.9% of inpatient and day case work was elective. This enabled staff planning to be done well in advance to ensure there were sufficient and appropriately skilled staff in place.
- We saw the KIMS Audit Programme which showed that outcomes were monitored, for example coronary angiogram outcomes. However, due to the current low numbers of patients many of the audits were not yet fully underway and limited data was available.
- We were told that the hospital participated in British Cardiovascular Intervention Society (BCIS) audits for cardiology interventions. The report had not been finalized at the time of the inspection.
- There was information and advice for patients following cardiac procedures.
- The Interventional Suite staff were trialling an electronic tablet questionnaire that was very quick and simple to use. We saw that the early results were positive for the patient experience.
- In addition, they selected a random sample of 65 NHS patients and those results were also positive. For example, 64 patients responded that the course of treatment or procedure was fully explained to them. The hospital shared the results with the NHS trust.
- There was no formal routine quality assessment or audit of outcomes for patients receiving end of life care. This meant that the service could not measure and track the quality of care provided to patients at the end of their lives.

- Because of the size of the service, the hospital had not participated in any national audits, accreditation or benchmarking exercises for end of life care and we were therefore unable to compare the service to other hospitals.
- A lack of Mortality and Morbidity meetings at the hospital meant that the management of patients who had died was not reviewed. This was a missed opportunity for improving end of life care at KIMS.

Competent staff

- We looked at the ward agency staff folder. The hospital used staff from a variety of nursing agencies. We found varied and inconsistent information supplied by the different agencies. For example, not all agencies supplied information on previous training, not all provided current curricula vitae (CVs).
- We saw that all agency staff underwent ward induction that included the location of equipment and documentation as well as the ward shift patterns. These records were kept on the ward and it was clear which agency each member of staff came from.
- We were told there was limited in-house training. For example, we found varied knowledge of care and treatment of patients living with dementia as well as the Mental Capacity Act and Deprivation of Liberty Safeguards.
- However, staff said they had opportunities to access additional training and spoke with one member of staff who had completed National Vocational Qualifications (NVQs) at levels two and three.
- We also spoke with a Band 7 nurse who was part way through a master's degree.
- We saw the cardiology teaching folder on the ward which provided information for staff who were interested.
- There was a 'champion' nursing system in place for patient dignity, infection prevention and control. Champions received additional training which they then cascaded to other staff.
- Some nursing staff had set up honorary contracts with NHS hospitals in order to maintain their skills. The hospital opened in April 2014 and was not operating at full capacity. This meant that staff were not treating large numbers of patients and were caring for patients from different surgical and medical specialties.
- Ward managers told us they had regular weekly one-to-one meetings with matron.
- Staff, medical and nursing, we spoke with described their appraisal and felt that it was a positive experience. These were carried out May and November annually. We saw three examples of appraisal documentation that included the corporate values, for example managing risk and caring, and objectives with measures to demonstrate achievement. There were written comments by the reviewer and the member of staff together with an overall rating.
- We saw an example of continuous professional development for medical staff that included up to date training in, for example, advanced cardiac life support, paediatric life support and handling violence and aggression.
- Each consultant practising at KIMS required a statement confirming their practice in the hospital and reporting incidents, complaints or concerns. Reporting of incidents, complaints or concerns was furnished by the Medical Director and supported by information from the governance team. If a serious incident took place or a concern arose relating to a consultant with practising privileges, this was communicated by the hospital's Medical Director to the Responsible Officer at the NHS Trust. This was a two way process and the Medical Director also received information from the NHS Trust Responsible Officer that could affect the consultant's practice in KIMS.
- The Endoscopy Unit was only utilised for four to five procedures on a Friday. This was a low number of procedures with which to maintain skills and competency.
- The end of life care service was very small, and the hospital had not provided any specific staff training in caring for patients at the end of their lives, although some staff we spoke with demonstrated good knowledge and experience of end of life care.
- There were no specialist palliative care staff at the hospital who could provide support and training to general staff. The hospital had made an arrangement with a telephone helpline service for staff needing advice when caring for patients at the end of their lives. Staff we spoke with were aware of this service but none had cause to utilise it and therefore its effectiveness was unproven.
- The RMO we spoke with was not trained or experienced in providing end of life care. They told us that they would refer to the admitting consultant if they needed support to care for a dying patient.

Medical care

Multidisciplinary working (in relation to this core service)

- We saw evidence of good multidisciplinary working between the different specialties. Physicians covered any medical conditions for surgical patients.
- There was a cardiology rota in place 24 hours every day.
- Nursing staff, consultants, physiologists and therapists all told us that they worked well together.
- The nursing staff in the Catheterisation Laboratories also worked on the inpatient ward. This enhanced relationships and communication.
- Most specialties did not hold MDT meetings which meant that plans for the treatment of patients relied solely on the opinion of one consultant and did not take into consideration the wider expertise available through effective MDT working.
- The cardiology department had telephone and video link meetings with an NHS hospital. The meetings included surgeons, physicians, radiologists, nurses, physiologists and GP liaison. Consultants presented their cases.
- The end of life care service at the hospital was under developed and the coordination of care for patients at the end of their lives was not formalised. There was no palliative care multidisciplinary team in the hospital and none of the three patients whose notes we reviewed had been referred to the palliative care multidisciplinary teams or specialists at local NHS hospitals.
- There had been no formal liaison meetings with local hospices to coordinate care for dying people, although their contact details had been made available to staff. The matron told us that she planned to hold liaison meetings in the near future.

Seven-day services

- There was sufficient access to screening and diagnostic services 24 hours a day, seven days a week.
- An on-call response system was in place out of hours that included radiology and pharmacy.
- Therapy services such as speech and language therapy were provided to KIMS by external providers on request. There were no formal systems for monitoring the quality of the service but patients and staff assured us the services were good. Patients records showed the input of therapists was appropriate and met the needs of patients.
- Consultants provided on-call cover for the duration of their patient's hospital stay.
- The RMOs provided 24 hour cover for the hospital, seven days a week.
- There was a seven-day medical admissions service available to GPs and consultants and managed by the senior nurse covering the hospital and holding the 7777 bleep.
- The physiologists worked from 8am to 5 or 6pm, with evenings as required. There was an on-call rota for 12 hours following procedures and from 5pm on Fridays until 8am Mondays. The laboratories and staff were available during major cardiac surgery.

Access to information

- Staff had access to the patients' medical records that included past medical history and information such as allergies.
- Staff had access to condition specific information and were able to support patients and relatives to make decisions about their care and treatment.
- Most investigations such as blood tests were undertaken on site and staff had access to the results for consultation and prior to treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients we spoke with told us that staff always asked them before carrying out any care or treatment. Patients felt that their views were respected.
- We saw evidence of completed consent forms in medical records we looked at. We did not identify any concerns regarding how consent was obtained.
- In three sets of medical records we reviewed, despite recording that the patient lacked capacity, we found no evidence of mental capacity assessments as required under the Mental Capacity Act.
- However, in the medical records of one patient on the ward we found a mental capacity assessment had been undertaken together with a best interests meeting with the family. There was a copy of the Power of Attorney that was in place and had been signed by the patient.
- The senior nurses we spoke with had received training in Duty of Candour and been provided with a teaching tool to cascade to the rest of the teams. This was an ongoing piece of work so we found varied knowledge amongst the less senior grades.

Medical care

- There was a policy in place for "Do Not Attempt Cardio Pulmonary Resuscitation" (DNACPR) decisions. This was part of the hospital's policy on resuscitation.
- We found some evidence of good discussions with patients and relatives regarding DNACPR decisions, however this was not consistent. For example we found evidence that discussions with one patient were unnecessarily prolonged over the course of three to four days.
- Neither of the two DNACPR forms we saw had been appropriately completed. We looked at two DNACPR forms and while one included evidence of an appropriate mental capacity assessment, this was undated. The other stated that the patient did not have mental capacity to make a decision about resuscitation but there was no evidence of a formal mental capacity assessment and it was clear from the nursing and medical notes that the patient did have capacity to make decisions.
- The DNACPR forms we saw had been signed by the patients' consultants. Forms should be kept as an original in a person's notes and not photocopied. One of the DNACPR forms we saw in the notes we reviewed was a photocopy.
- An audit of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders had also been completed against the guidance of the NMC. Problems found from the audit included a patient who did not have capacity, a patient with no valid advanced decision recorded and a patient with no appointed welfare attorney. The audit had been completed using Resuscitation Council (UK) 2015 recommended standards for the recording of decisions about DNACPR. The audit was due to be responsible for areas of non-compliance had been briefed on the requirements.
- The results of the audit were e-mailed out to each department but it was not clear how learning was disseminated to all staff and followed up to improve care.

Are medical care services caring?

Good

Patients and their relatives were very positive about their care during their hospital stay. Patients described how staff were professional and knowledgeable and supported them in a compassionate and caring manner. Staff protected patients' privacy and dignity and treated each patient as an individual. Patients felt well informed about their condition and treatment plans. They told us they were involved in planning their care. Relatives said they were well communicated with and confident that they could ask questions. We observed that staff addressed patients kindly and were friendly, courteous and helpful to patients and visitors.

Compassionate care

- We observed the ward staff providing kind, caring and compassionate care for their patients.
- We spoke with the relative of a patient with complex conditions that included living with dementia. We were told of very high quality care by the nurses and the efforts made to understand the patient and their needs.
- We saw a 'thank you' email sent to the oncology nurse regarding a patient's chemotherapy treatment that was completed in August 2015 (the hospital were not providing further chemotherapy treatment at the time of the inspection visit). It described the professionalism, knowledge of the treatment, skill and helpfulness and good humour that helped the patient maintain a positive attitude.
- Patients we spoke with told us their privacy and dignity was protected. Staff knocked before entering, curtains were used appropriately and chaperones offered and provided if required.
- Patients described staff as very caring. Staff talked to patients and explained what they were doing.
- Patient comments included, "100% - cannot fault them at all."
- Whilst there were moderate response rates (between 31% and 60%) for the Friends and Family test (FFT), there were consistently high results (above 85%) for the reporting period October 2014 to March 2015.
- The hospital had a robust and effective method for gathering patient feedback on their experience of care and treatment at KIMS. Patient satisfaction surveys had been implemented for inpatients, day care and outpatients. However, it was not possible to separate results for medical patients.
- The staff we talked to spoke with compassion about patients they had cared for at the end of their lives.
- There was evidence of good care recorded in the notes of the three end of life care patients we reviewed. For

example nursing staff had made detailed notes regarding a significant discussion between the patient and their consultant covering all aspects of their care and detailing their wishes.
- Staff told us that they had arranged and facilitated a wedding in the hospital of one patient who was being cared for at the end of their life. This was recorded in the patient's notes.
- The staff we spoke with were aware of their responsibilities to be respectful and to honour people's wishes after death.
- There was no policy in place for organ and tissue donation although this was included in the draft end of life care policy that we saw. This meant that, at the time of our inspection, there was a risk that patients' wishes for organ donation might not be honoured.

Understanding and involvement of patients and those close to them

- One of the relatives we spoke with told us that the staff explained everything and communicated with them if they were concerned and updated them on how the patient was progressing.
- Patients felt fully involved in their care planning with time to discuss any questions or concerns with their consultants, the RMO and nursing staff.
- Staff described how individualised care was planned with the patients. The hospital offered a named nurse system. This meant that patients had a designated nurse responsible for their care during their stay. This promoted continuity of care.
- There were leaflets regarding local information for carers on the wards.

Emotional support

- KIMS had access to two qualified counsellors to provide emotional and other support for patients and their families.
- There was a quiet room on another ward that was available for patients and their families.
- The majority of emotional support was provided by the nursing staff on the ward. Patients we spoke with told us the staff were very supportive and they felt able to discuss any concerns with them.
- We saw there was a variety of information to support patients such as information from the local carers' project, and from Breast Cancer Care – Supporting people with learning disabilities to take care of their breasts.

Are medical care services responsive?

Good

Access and flow was good but the hospital was not operating at full capacity at the time of the inspection. Staff assessed patients' individual needs and took account of their preferences. Staff promoted patient centred care. We found that patients were included in decision making and their human rights were respected. There was a complaints process in place. Themes and trends were collated and discussed at senior level. Learning was disseminated to all staff.

Service planning and delivery to meet the needs of local people

- We were told of the relationship developed with a local NHS Trust following carrying out approximately 150 procedures in the Cath Labs to assist the trust with winter pressures. This meant for these patients their procedure was not cancelled. Discussions were in place for this winter.
- The end of life care service at KIMS was in its infancy. The hospital management team had a number of actions planned to meet the needs of people at the end of their lives. These included setting up arrangements for rapid access referrals and to provide access to complementary therapies and information for patients.
- People's relatives were offered a room in which to stay if they wanted to be close to their loved one. There were also reclining chairs available if relatives preferred to stay with the patient in their room.
- The hospital had a service level agreement with a local funeral director who would offer mortuary facilities on behalf of the hospital. The hospital porters were not involved in transferring deceased patients to the funeral director's mortuary. We did not inspect the mortuary service as part of our inspection.

Access and flow

Medical care

- There were no concerns regarding patient flow within medical care. However, it is important to note that the hospital was not operating to full capacity at the time of the inspection.
- GPs and consultants could access the seven-day medical admissions service that was managed within the hospital by the senior nurse covering the whole hospital and holding the 7777 bleep. We saw the pathway and documentation in place as well as the on-call rota for consultants.
- A discharge pathway for patients was in use on the ward. This meant that patients had all the relevant information they needed before their discharge.
- Electronic letters were sent to patients' GPs to ensure they were kept up to date on progress and any ongoing treatment plan.
- One patient in for a day care procedure told us that the whole process had been efficient. Staff did the discharge paperwork with the patient an hour before they were due to leave. The patient's follow up outpatient appointment had already been arranged with them.

Meeting people's individual needs

- Patients' individual needs were identified at pre-assessment or on admission.
- We were told that patients living with dementia and/or at risk of falling were accommodated near the nurse station and that 1:1 nursing care would be considered. On the first day of the inspection there was a patient living with dementia who was close to the nurse station and provided with a non-registered nurse to ensure their safety.
- We were told that this support would be available for patients with learning disabilities or other extra needs if required.
- We asked whether any changes would be made to the bedroom to support a patient living with dementia, for example a large clock, and were told that there would not be. However, patients at risk of falling all had risk assessments and could have high/low beds and floor mats beside the bed. We saw examples of falls risk assessments in the patient records we looked at.
- Translation services were available on request.
- KIMS had a service level agreement with a local healthcare provider to ensure that patients with mental health issues could be appropriately cared for.
- We were told that the RMOs and consultants responded in a timely manner when requested to see a patient.
- The recovery area for the Cath Labs consisted of cubicles. These were not single sex accommodation and patients were advised of this in advance of admission.
- There were a variety of information leaflets available for patients that included: sedation, cessation of Warfarin and bowel preparation.
- There was a wide selection of national bodies' information such as NHS Blood Transfusion and the British Heart Foundation.
- Detailed strategic plans for the end of life care service at KIMS had not yet been developed. The matron told us that these would be developed once the appointment of a palliative care consultant had been finalised.
- Some spiritual support was available to patients receiving end of life care at the hospital. We were shown a list of providers of spiritual support and their contact details although spiritual support was not yet available for people of all faiths. Staff we spoke with had knowledge of different faiths and how to care for the person's body appropriately.
- None of the three patients whose notes we reviewed had an advance care plan and so we were unable to make a judgment about how staff were involved in advance care plans.
- Staff used a blue butterfly logo that was placed outside the door of a patient receiving end of life care. This would alert staff to be considerate to the needs of the patient and family at this difficult time and keep the atmosphere as calm as possible.
- There was a "last offices" box and guidance for staff on dealing with patients who had died and preparing the body for transfer to the funeral director's premises. This contained a flow chart and check list to ensure that staff respected the person's spiritual and cultural wishes and maintained the privacy and dignity of the person after their death.

Learning from complaints and concerns

- The Director of Clinical Services was responsible for overseeing the management of complaints.
- Information for patients on how to make a complaint was in each bedroom as well as at the nurse station.
- There were effective systems and processes in place to manage comments and complaints. Themes and trends were collated and discussed at the monthly Clinical Effectiveness meetings. We saw examples of the details on individual complaints that were presented in the Clinical Effectiveness Report prepared for each meeting.

Medical care

- There were low numbers of medical patients treated at KIMS and we did not find complaints directly about this core service.
- Patients we spoke with told us they felt confident that any concerns they raised would be listened to and managed appropriately. They did not feel that they would be discriminated in any way by raising concerns or making a complaint.
- Following closure of a complaint the hospital sent a questionnaire to obtain feedback on their management of the process.

Are medical care services well-led?

Requires improvement

Overall there was a lack of clear leadership of specialist medical services at KIMS. There was good local leadership on the ward and exceptional leadership in the Interventional Suite but these were provided mainly for the surgical patients. There was a lack of effective clinical leadership of specialist services.

The governance systems were very poorly developed and ineffective. There was a new governance lead and a new CEO in post but the impact of these appointments was not yet visible. Governance was not seen as an issue for everyone. Medical staff were not engaged with the development of better clinical governance systems and oversight of quality and safety was missing.

There was lack of oversight of the Endoscopy Unit and no assurance in place that the safety and governance processes were working.

End of Life care was not developed. There was no formal structure with expert clinical input, no monitoring of the quality of end of life care and no designated lead at a sufficiently senior level to bring about change. There was a high level of commitment and enthusiasm for developing the service and the hospital management was working to put suitable processes in place.

The organisation had no leadership of palliative medicine at either at board or clinical level. However, the hospital had identified this and had plans to make these improvements.

Staff felt involved in the vision for the hospital and were happy to be working at KIMS. They described an open culture with good board to ward and ward to board communication. Staff felt able to express their ideas for improvement.

Vision, strategy innovation and sustainability for this core service

- There was an appropriate vision and strategy for the service. The departments were striving to develop and expand their service to improve capacity and improve efficiency.
- Staff felt involved in developing the services and able to bring ideas forward.

Governance, risk management and quality measurement for this core service

- Policies and procedures, including information on incidents, were on the shared drive and available for all staff. However, several required review and ratification.
- There was insufficient oversight of the endoscopy service with low numbers of procedures and an environment that was not fit for purpose.
- We saw that the risk register reflected identified risks to the service. For example, there was lack of communication between IT systems in the Interventional Suite and the hospital system. There was a risk assessment in place, the risk register was updated monthly with the investigation progress and a robust process was in place to input the information manually in the interim.
- Some of the advertised medical services were not provided at the time of the inspection visit, for example intrathecal chemotherapy.
- The hospital introduced a 'clinical services circular' for staff to raise awareness of issues such as the Mental Capacity Act and the Duty of Candour. It also included learning from incidents and complaints.
- The results of patient surveys was analysed with actions taken to address any shortfalls. These actions were also followed up and outcomes monitored.
- There were patient feedback forms in all waiting areas we visited as well as in each bedroom.
- We saw evidence that complaints and incidents were discussed at appropriate committees and at senior level.

- An end of life care group had recently been set up by the matron who was clinical lead for end of life care. However, this was not a multi-disciplinary group and did not include a member of the hospital's Executive Committee.
- There were no specific governance arrangements or criteria for the admission of patients at the end of their lives. This meant that specialists could admit patients for end of life care whose needs may not be best met by the hospital.
- The matron identified the lack of a ratified end of life care policy as a risk to the hospital; however, this had not been included on the hospital's risk register at the time of our inspection.
- Because of the size of the EOLC service, there were no formal arrangements in place to monitor and manage the quality and performance of the service.

Leadership/culture of service (related to this core service)

- Staff told us that they felt well supported by senior management who were all considered visible and approachable.
- Staff said they were happy working at KIMS and felt proud of the service they provided.
- Staff felt able to voice opinions and cited KIMS Voice as an example.
- There were regular staff meetings to share information and discuss any issues or concerns to be fed back to senior management.
- Leadership in the ward areas was found to be good. We were told of the challenge of having three managers in one ward area because the service was still being developed and the hospital was not operating near capacity. The teams were working towards standardised working practices.
- The Manager of the Interventional Suite confirmed they had meetings with the Chief Executive and Medical Director and discussed the business plans with the Business Manager. They were a finalist for the Independent Health Care Catheterisation Laboratory award.
- There were consistently low sickness rates (below 5%) for inpatient nursing staff during the period April 2014 to January 2015.
- There were low vacancies (less than 10%) for inpatient registered nurses with no vacancies for inpatient non-registered nurses during the period April 2014 to March 2015. However there were moderate levels of staff turnover (20% to 39%) for the same period.
- The matron made efforts to ensure the end of life care provided by the hospital was to a good standard amid demands for high quality services across the remainder of the hospital.
- Seven staff in the hospital participated in the end of life care group. This group was involved in the planning and development of the end of life care service at the hospital. We looked at the minutes of a meeting of this group and saw that staff were encouraged to be involved in the service. We also saw that the group planned to hold a seminar for all staff once all end of life care information and planning had been finalised to ensure their awareness of this service area.

Surgery

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

Information about the service

The Kent Institute of Medicine and Surgery (KIMS) Hospital is a new and large independent hospital in Kent that provides surgical services for both NHS and private patients. It has 99 beds, five theatres, two endoscopy suites and two interventional labs. However, at the time of inspection the surgical department was not operating to full capacity. Twenty five inpatients beds were in use. The service offered a range of surgical procedures and diagnostics. In order to carry out the inspection, CQC reviewed a large volume of performance data, spoke to patients and their relatives, held focus groups for staff and listened to the views of the public as well as reviewing patient satisfaction questionnaire results. In total we spoke to eleven patients, three relatives, and 21 staff.

Summary of findings

We identified some concerns and rated the surgical department at KIMS hospital as requiring improvement overall. This was a score that reflected the need for improvements in the 'Well led' domain and inadequate rating in the safety domain. Of the remaining three domains two were rated 'Good' and there was not sufficient evidence to rate the other.

Improvements in the way incidents were collated, investigated, learned from were necessary. The systems to report incidents through the national frameworks were insufficiently robust. The department had not developed mortality and morbidity meetings to learn from mistakes and prevent recurrence.

The emergency call system was broken. The provider knew about this for some time and identified it as a risk to patients but they still had not repaired it.

The infection control policy was not being adhered to by all staff. We observed staff failing to comply with the hospital policy on being bare below the elbows and hand washing policy. The department had only started auditing to the National Standard of Cleanliness in the NHS Schedule two weeks before the inspection. This meant there was no quality assurance about environmental cleanliness in what is considered a high risk clinical area.

Surgery

Compliance in use of venous thromboembolism (VTE) prophylaxis was identified as poor. However, this was recognised by the provider and was being addressed. Recent audit demonstrated an improvement in compliance.

WHO Surgical Safety Checklists were not completed routinely.

There was no major incident plan. Staff did not have a clear understanding of what a major incident was or the role expected of them should one occur.

The governance, risk management and quality assurance processes were not robust enough to assure the provider that the care they provided was safe. A new governance manager had been appointed but they had not been in post for long enough to see an impact.

Management sent staff policies before they were ratified, and others were out of date. There was no oversight of the quality of services provided by external providers. The provider purchased some patient services (e.g. physiotherapy) from third parties. There was no monitoring of how effective the services were.

We reviewed forty sets of medical records during the inspection which highlighted that some improvement was necessary in terms of the documentary evidence available to track patient outcomes. We saw cases where follow up should have been arranged but there was no evidence in the notes (such as GP letters or follow up appointments) to show this had been done. There was no record that some patients undergoing surgery for cancer were followed up in accordance with local and national guidance. The risk was that the patients might not have been followed up and that the staff at KIMS were unaware of this.

Patients were involved in their care planning and had their personal preferences respected.

There were sufficient staff, with the right skills that had access to on-going training to meet patients care needs.

We found the care and treatment took account of published research and national guidance. The hospital also used the findings from local and national audits to ensure that action was taken to protect patients from the risk associated with unsafe care and treatment.

Patients who used the service were protected from the risks of abuse occurring. They had their care needs risk assessed on admission. Medical records demonstrated that identified risks were addressed. The department evidenced being able to meet peoples complex care needs for example those with learning difficulties, mental health conditions or dementia.

We found medicines were handled and stored securely. Staff had undertaken a competency based assessment to ensure the highest standard of medicine administration.

Staff had access to sufficient equipment to ensure they could meet people's needs. We found evidence of equipment maintenance schedules and service level contacts that meant equipment was being regularly serviced. There was sufficient competency based teaching provided to ensure staff felt supported to use the equipment provided.

There was an appropriate pathway to identify and care for deteriorating patients. There was sufficient medical cover to meet patients' needs. We found adequate access to screening and diagnostics seven days a week. Care was delivered from a multidisciplinary perspective, for example physiotherapy, occupational and speech and therapy services. These services were provided by external health care providers.

Staff told us they felt proud to work at KIMS. They told inspectors the department had an open and transparent culture and patients centred approach to the work undertaken in the department. Staff described feeling respected and involved in the development of the KIMS vision and strategy.

There was evidence of a strong and inclusive leadership in the department. We found effective systems in place that encouraged staff engagement.

There were effective systems in place to deal with comments and complaints, including providing patients with information about how to raise concerns or make a complaint.

Surgery

Are surgery services safe?

Inadequate

We have judged the services delivered in the surgical department of KIMS hospital as inadequate because: Incident reporting, investigation and trend analysis were insufficiently robust and there was very limited learning from incidents. What learning occurred was localised and not disseminated across the organisation.

We were also concerned about how near miss never events were identified, reported and learned from. There was no evidence that mortality and morbidity (M&M) meetings were used as a tool to improve services. M&M meetings are usually peer reviews of poor patient outcomes, mistakes or clinical incidents occurring during the care of patients. There were records where there was no evidence of multidisciplinary review following surgery for cancer.

The emergency call system was broken and had been in a state of disrepair for an extended length of time without being fixed. The provider knew about this for some time and identified it as a risk to patients but they still had not repaired it.

KIMS did not have an effective major incident plan in place. Staff did not have insight into what a major incident was and were not aware of their roles should one occur.

We found the KIMS infection control policy reflected national guidance and the areas we visited were visibly clean and tidy. However, staff did not always follow the infection control policy and application was not consistent throughout the organisation. We identified a consultant who was not 'bare below the elbows' when in direct contact with a patient. Bare below the elbows allows staff in contact with patients to effectively wash their hands and wrists between each patient and reduce the risk of cross infection. We also observed a nurse handling bodily fluid without an apron which risked contamination of their uniform and posed a risk of transferring infection between patients. The floors in consultation rooms had carpet which is not in line with national infection control guidance. We also noted a bin in the theatre staff toilet that was not conducive with did not open hands free operation. We requested six months data to demonstrate the department was adhering to the national standard of cleanliness guidance. However, we found the hospital had only implemented the audit process two weeks before the inspection.

We noted from the data provided to us that there was high surgical site infection rates reported for a two month period for orthopaedic surgery.The department were taking action to monitor and address the suspected high infection rates. The RMO was monitoring the increase in infection related to orthopaedic surgery but this was not being managed at a senior level within the organisation.

Data supplied to CQC by the provider showed poor compliance with the WHO Surgical Safety Checklists. It is recognised that the most recent month showed 100% compliance but prior to this there were levels of 89% compliance.

The quality of record keeping was variable. Some notes that were reviewed did not show any follow up following surgery, no recorded patient outcomes and no referral or GP letters.

High levels of agency staff use posed a potential risk of staff working in an unfamiliar environment.

The department reported low levels of MRSA (methicillin-resistant Staphylococcus aureus) and C. difficile (Clostridium Difficile). Staff had access to good quality equipment to enable them to do their jobs. Patients were cared for by sufficient staff with the appropriate levels of training. Medications were handled and administered in line with national guidance. Patients received their medication on time and when requested. Patients were protected from abuse, the risk of abuse and their human rights were respected and upheld. Medical records were stored securely and remained confidential.

Incidents

- Incidents were being consistently reported in the surgical department. Managers shared learning from individual incidents with staff via email and at staff meetings. However, data was being collected in paper form which meant the analysis of the incidents was difficult although some trend analysis was being done.
- Trends and themes from an organisational perspective were not being collated and opportunities for learning from incidents were missed. The service carried out Root Cause Analysis (RCA) investigations. However, the

RCA reports that we looked at lacked sufficient analysis and recommendations. Action plans were weak or did not exist. The service did not monitor how the staff implemented actions in the clinical areas. There was not clinical lead that had overall responsibility for the RCA process.

- We also identified some incidents where a RCA investigation had not been carried out. This demonstrated a lack of understanding of the national RCA criteria. Staff, who carried out the RCAs confirmed that they had did not received training to carry out such investigations.
- Whilst the organisation did report incidents that required investigation, the quality of the investigation, impact on learning and prevention needed to be more robust.
- The provider reported no never events in the last 12 months. Never events are serious, largely preventable patient safety incidents that should not occur if all preventative measures have been implemented.
- A member of the medical staff we spoke with was unable to tell us what might constitute a never event and could not give us any examples.
- We found that STEIS reporting (National Framework for Reporting and Learning from Serious Incidents Requiring Investigation) was not as robust as it could be and the reporting criteria was not well understood by staff.
- Staff reported an incident where a patient was being administered a spinal block to the wrong leg. Neither the anaesthetist nor operating department practitioner (ODP) made the surgeon or staff aware of the clinical error. The error was identified when the patient returned to the ward and staff alerted the surgeon that the patient had no feeling in the wrong leg. This incident was fully investigated, addressed with the individuals involved and an action plan was put in place to avoid recurrence. This demonstrated that the WHO Surgical Safety Checklist was not always being used effectively to prevent errors occurring. This event would now be considered a Never Event under current NHS England guidance but wrong site nerve blocks were specifically excluded at the time the event happened.
- Incident forms we viewed and the organisation's risk registers indicated a problem with the hospital emergency call system. The system relied on radio receivers and mobile phones that did not have adequate coverage to receive a call. This meant that staff were unable to raise the alarm to alert key staff of a medical emergency. The concern was on the risk registers for a significant length of time without being addressed by senior management. This was a significant and unnecessary risk to patients who used the service.
- There was no evidence that mortality and morbidity was reviewed in the department. Mortality and morbidity meetings (a key component of workplace-based learning where clinicians discuss errors and adverse events in an open manner, review care standards, and make changes if required) were not in place in the department. This meant that organisations were missing an opportunity to learn and improve.
- Staff told us that the Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were disseminated to staff via the pharmacy and procurement departments. However, we did not see evidence that this process was in place.
- We found a standardised approach had been taken when designing the layout of the anaesthetic and operating theatres. Standard specifications and layout in a theatre department helps to improve health and safety performance.
- Some staff struggled to demonstrate a clear understanding of their Duty of Candour. This had been identified by the senior management team as a known risk and work was being done to provide training for staff.
- CQC were aware of a concern raised by a patient who attended for eye surgery. They told us they had requested a particular high grade lens to be fitted. However, halfway through the operation staff realised they did not have the correct tool to fit the lens. Staff eventually found the necessary tool and no harm came to the patients however the event extended the theatre time and caused unnecessary anxiety for the patient.

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

- A Safety Thermometer allows teams to measure harm and records the proportion of patients that are 'harm free' during their working day. Safety Thermometer data also helps teams in a wide range of settings, from acute wards to a patient's own home, to measure, assess, learn and improve the safety of the care they provide.

- Safety thermometer data was being collected. However, the data was not being displayed in public areas as expected. This meant that patients and staff did not have easy access to data that demonstrated a harm free care environment.

Cleanliness, infection control and hygiene

- Data provided by the department demonstrated very low levels of MRSA (Methicillin-resistant Staphylococcus aureus) and C.difficile (Clostridium Difficile).
- The surgical work carried out at KIMS was entirely elective which allowed for all patients to be screened for infections prior to admission. Patients had single rooms which also reduced the risk of cross infection during their admissions. This meant that the department had a robust way of monitoring and identifying infections before surgery and isolating the infection, if one was identified.
- Hand sanitisers were available by the nurses' station on the ward. However, hand sanitisers were not available either outside each single room or immediately inside the rooms. This would promote staff hand hygiene in line with guidance such as the World Health Organisation "Five moments for hand hygiene".
- We also observed a consultant have patient contact who was not bare below the elbows and a nurse who was handling bodily fluids without an apron. This meant that the infection control policy was not always being followed by staff. There was ample access to Personal Protective Equipment (PPE). We observed the majority of staff adhering to the policy and best practice guidance
- Data provided indicated that surgical site infection rates were high. For example data showed us that five infections were identified in a two month period for orthopaedic surgery. The RMO had identified this as a concern and had begun to take action to address these findings. There was no organizational responsibility for investigating this increase and an RMO investigating surgeons might prove difficult because of their lack of seniority.
- Cannulas were dated on insertion and documentation demonstrated regular checks for signs of phlebitis.
- Clinical waste was separated and stored in line with national guidance.
- The disposal of contaminated sharps was also in line with national guidance.

Environment and equipment

- The theatre and ward areas had access to the newest equipment to be able to do their jobs. Staff told us they had no concerns with getting equipment when they needed it.
- The ward area and theatres had access to emergency equipment. The equipment checking logs demonstrated that checks were carried out routinely.
- Appropriate maintenance schedules and contracts were in place.

Medicines

- Ward medicines trolleys were of an inadequate size. In addition, during the medicines round we observed that patients own drugs were stacked on dressings trolleys.
- Controlled drugs (CD's) were ordered, stored and returned to pharmacy in accordance with guidance.
- CD's were tracked and signed out by two members of staff at all times. The records seen showed us that staff were checking the stock levels in line with the hospital policy.
- Fridge temperatures were recorded daily, in line with best practice.
- Medication was administered at the prescribed time. This was reflected on the Medication Administration Charts (MAR) that we reviewed and in the conversations we had with patients.
- Antibiotic usage was being closely monitored in the department by the pharmacy team to ensure best practice in the use of antibiotics was being followed.
- According to the hospital policy ward medicines auditing should have occurred every three months, however, this was not achieved. Pharmacist support was available and utilised by the ward.
- Staff were required to undertake a competency based assessment before they were allowed to administer medication.
- Epidural fluid was stored separately from intravenous fluid, which is in line with national recommendations.
- The service monitored the quality of medical air produced via on-site compressors.
- The service had segregated stores for empty and full medical gas cylinders.

Records

- Medical records in the surgical department were stored securely to maintain confidentiality.

- Patients had a range of risk assessments carried out on admission to the hospital. This included use of the Malnutrition Universal Scoring Tool (MUST), Venous thromboembolism risk assessment (VTE) Falls risk assessment, Cannula, Pain and skin assessments.
- We reviewed the nursing notes for 10% (five sets of notes) of the surgical inpatients admitted at the time of the inspection. The assessments were fully completed for each patient on admission.
- Patients were offered a pre-operative assessment before their surgery. This process involved answering questions about their health, medical history and home circumstances. It also provided information to patients about what to do before admission as well as providing an opportunity for a range of basic tests and an infection screen.
- Patients had their observations documented accurately throughout their stay.
- We reviewed 40 sets of medical records which showed variable quality of the documentation. For example, notes did not always contain details of necessary follow ups or outcomes after surgery, consultant and GP referral letters or pre assessment documentation.
- Inpatient and day surgery medical records were retained securely on the KIMS premises.
- There was a lack of documentation demonstrating multidisciplinary team reviews for patients following surgery for cancer. There was no documentation that outlined the patient pathway in terms of a follow up post operatively.
- Loose pages of clinical information were found in some notes which meant this information was at risk of being misplaced or lost.
- Two out of five Pressure damage risk assessments that we saw had been scored incorrectly.

Safeguarding

- Staff were aware of their role in identifying and raising a safeguarding concern.
- Staff demonstrated an understanding of the pathway used to report a safeguarding concern.
- The Director of Clinical Services was the safeguarding lead for the hospital and had good oversight of the patients in the hospital.
- Staff we spoke with, nursing and medical, described safeguarding training as part of their mandatory training. We were told that safeguarding was part of staff induction with biannual e-learning updates.
- We saw safeguarding training on the ward training matrix we looked at. The training covered children and vulnerable adults.
- Safeguarding training compliance rates for the surgical department was not able to be divided into surgical staff as many staff carried out care for patients using several core services. For example, ward staff cared for medical and surgical patients.

Mandatory training

- Staff had been provided with mandatory training in a number of areas such as fire safety, infection prevention and control and safeguarding.
- Staff were encouraged to acquire additional skills and qualifications relevant to their positions.
- We saw the training matrix for staff on Nickleby Ward that showed all staff were up to date for training such as moving and handling and fire safety. The matrix identified that training had recently been introduced for: infection prevention and control; health, safety and welfare; equality and diversity, and paediatric immediate life support (PILS). We saw that staff were booked on to modules and that this was monitored.
- The staff told us that they had a training passport that was held centrally by the human resources department. We saw several examples of these that confirmed their use.
- Mandatory training compliance rates for the surgical department were not able to be assessed as a whole unit as the staff cared for people using different core services. Compliance rates across the hospital were high with levels in excess of 98%. Shortfalls were attributable to new starters or staff on prolonged leave.

Assessing and responding to patient risk

- The department was using the National Early Warning Score (NEWS) scoring system to identify and escalate care of any deteriorating patients.
- When a patient was identified as deteriorating by nursing staff their concerns were immediately escalated to the RMO who provided an instant review and updated the treatment plan.
- Blood for transfusion was ordered in for named patients where it was needed for elective surgery. The department also kept a stock of O negative blood on site for emergencies. There was also an arrangement with a local trust called “Code Red”. This meant that six units of blood and six units of frozen plasma would be

immediately provided to KIMS, if requested. If the RMO was concerned about a patient's condition they contacted the consultant to make them aware of the situation.

- The theatre department had implemented the World Health Organisation (WHO) five steps to safer surgery. There was an established audit process that demonstrated 100% for September. However, audit data reported in the Surgical Audit plan showed a compliance rate in theatres of 89% between 1 June 2015 and 1 July 2015. An action plan had been put in place to ensure compliance improved.
- Staff were able to provide inspectors with examples of when the WHO checklist had prevented wrong site surgery in the department.
- We saw a briefing undertaken, in theatre, by all staff before a procedure began. This was done several times a day by the theatre team because the surgical speciality and consultant teams changed throughout the day. This meant there was a high standard of pre-operative checking and an embedded culture of patient safety in theatres.

Nursing staffing

- Patients and their health and welfare needs were met by sufficient numbers of staff.
- Planning of staffing took place at a daily operational meeting. The department took the Royal College of Nursing (RCN) guidance into account which recommends 65% registered nurse and a 35% health care assistant skill mix when planning staffing.
- The department also used an acuity tool to determine adequate staffing levels based on the dependency levels of the patients.
- We saw a handover and found it to be a structured and effective communication tool which promoted continuity of good care.
- The handover used the Situation-Background-Assessment-Recommendation (SBAR) tool. This is a tool that is used to improve patient safety and communication.
- All temporary staff employed at KIMS had undergone a formal induction programme.
- Between Sept 2014 and August 2015 the ward area used 2943.75 bank hours with 1533.75 used in theatres. Agency usage for the same time period was reported as 503.25 hours for the ward area and 315.75 hours in theatres. High bank and agency use was necessary to allow the provider to manage the unpredictable workload.
- It was not possible to break the data for the ward into a medical/surgical split.
- We attended a daily planning meeting. These were held at 11am with representation from each department. The meetings included reviewing patient and staff numbers. The whiteboard in the room was updated to accurately reflect activity and staffing numbers. Minutes were not kept of the meetings.
- In addition there was a weekly meeting held each Friday. The purpose included planning resources for the following week, including any staffing concerns.
- We were told that the ratio of nurses to patients should be 1:5 but was sometimes worse than that and could be 1:7. We could not identify any negative impact of this from our inspection visit when the service was well staffed.
- Staff were expected to be flexible and either come in or be stood down at 24 – 48 hours' notice. The hospital had very recently introduced a four day booking route that enabled off duty to be looked at earlier and gave staff a bit more notice.
- Some nursing staff had set up honorary contracts with NHS hospitals in order to maintain their skills. The hospital opened in April 2014 and was not working at full capacity. This meant that staff were not treating large numbers of patients and were caring for patients from different surgical and medical specialties. The risk was a loss of the staffs' skills if they were not using them regularly.
- We were told that refresher courses were planned for the medication competency assessment. The hospital had linked up with a nearby NHS hospital for a course in IV fluids, venepuncture and cannulation training starting in December 2015.
- Theatres had a "high efficiency" approach to staffing operating lists. This meant that lists were staffed with three scrub nurses and a runner.
- We looked at the ward agency staff folder. The hospital used staff from a variety of nursing agencies. We found varied and inconsistent information supplied by the different agencies. For example, not all agencies supplied information on previous training, not all

provided current curricula vitae (CVs). The risk of this was that staff presented by the agency might not have sufficient relevant experience for the role they were undertaking.

Surgical staffing

- The RMO took clinical responsibility for the patients 24 hours a day. The RMO's were supported by individual consultants who were contactable twenty four hours a day by telephone. The RMO's told us consultants were approachable and provided appropriate support.
- Daily handovers between one RMO to another RMO were in place. If there was a specific concern about a patient then the designated consultant was responsible for handing over to the RMO on duty.
- The surgical department had 24 hour consultant led care with each consultant taking responsibility for their own patients. Consultants remained on call whenever they had patients in the hospital.
- Large numbers of consultants with admitting rights posed a risk of surgeons working in an unfamiliar environment, with a team they did not know and equipment they were not used to. One record showed that an incident had occurred where a surgeon had burned the inside of a patient's cheek because they were unfamiliar with the equipment being used.

Major incident awareness and training

- There was no major incident plan in place in KIMS. This meant that there were no arrangements in place for dealing with unforeseeable emergencies.
- Staff were unable to provide an explanation of what a major incident was. They were also not aware of their role should a major incident occur. We have identified this as a significant risk to the organisation.

Are surgery services effective?

Not sufficient evidence to rate

We have not given the effectiveness of surgery as there was not sufficient evidence to rate this service. However we found:

Patients' did not always receive evidence based care that reflected best practice and national guidance. For example, breast surgery was offered for women at KIMS but they did not have access to the range of services that would be provided at a designated one-stop breast clinic.

VTE assessment and prophylaxis was insufficiently embedded in pre-operative care planning.

Numerous policies required ratifying and should not have been shared with staff until this had been done. Some policies were unavailable and some were out of date. Mortality and Morbidity meetings were not taking place.

The underutilisation of the hospital and low patient throughput created a risk that staff were not maintain their skills and keeping up to date with any changes to practice. This was particularly true of services which were only undertaken occasionally.

Very high number of consultants with practicing privileges and admitting rights posed a risk that patients could be admitted under the care of surgeons who were unfamiliar with the environment, the policies and the equipment.

Patients had their pain and nutritional requirements risk assessed and addressed in a timely manner. Pain and nutritional scores were regularly documented and acted upon by nursing staff. The patients we talked with told us their pain and nutritional needs were managed appropriately during their admission.

We found a multi-disciplinary team (MDT) approach to the care delivered in the department. This was evident from our conversations with patients and staff as well as from the medical records we reviewed. Therapy services were largely provided by third party healthcare providers which accounted for most multi-disciplinary services. The department made arrangements to ensure out of hours access to diagnostic, screening and therapy services whenever necessary.

Staff followed national guidance to ensure that patients were not left for long periods of time without adequate nutrition and / or hydration. Fasting times were in line with national recommendations.

There was an ample supply of information about specific conditions available for patients to access.

Consent was obtained in line with national guidance.

Evidence-based care and treatment

Surgery

- We found appropriate systems in place that demonstrated the service took account of published research and national guidance. However these were not always adhered to.
- Breast surgeons operated on women at KIMS however, there was no dedicated one stop breast clinic and no access to the full range of testing on initial referral as recommended in NICE Guidance CG 80.
- We carried out a concise review of medical records from various surgical specialities during the inspection. We identified a patient that had a psychological assessment that suggested the patient was not ready for surgery. The procedure happened quickly against psychological advice. This patient's BMI (Body Mass Index) was lower than the NICE recommended BMI for this procedure. This meant that national guidance was not followed in this instance.
- The unit also used the findings from local and national audits to ensure that action was taken to protect patients from the risks associated with unsafe care and treatment.
- We found the unit was implementing recommendations from NICE Clinical Guideline 83 on critical care follow-up and rehabilitation by developing a dynamic robust rehabilitation service for patients.
- We found hospital policies were based on NICE/Royal College guidelines. These policies were available in paper form to ward staff.
- Staff had to confirm they had read the policies by providing a signature and date on the day they were updated. The list we reviewed was not always complete so this meant that there was no guarantee that staff were aware of specific policies. We reviewed a list of 62 policies, 19 were unapproved and 25 were missing.
- We also identified policies that had expired and required updating, for example the management of Clostridium Difficile and Care of Patients with or at risk of Creutzfeldt-Jakob disease (CJD) or Variant Creutzfeldt-Jakob disease (VCJD).
- Care was provided in line with NICE CG50 (Acutely ill patients in hospital) and CG83 Rehabilitation after critical illness.
- The physiotherapy service was commissioned by from an external provider. We found the standard of service provided to be of a high standard which met national standards and clinical guidelines.

Pain relief

- Patients had their pain needs assessed and addressed in a timely manner.
- Comments received from patients included, "They ask about my pain every time they come into the room", "My pain was well managed", and, "They ask all the time about my pain".
- Data reviewed demonstrated that the surgical department compliance rates for completing a pain score with every set of observations was100% between Jan and July 2015.
- We saw evidence that patients had their pain needs assessed at their pre-operative assessments and on admission to the ward areas.
- The service provided a range of analgesia option to patients. For example oral, intravenous, PCA (Patient Controlled Analgesia), epidural and spinal blocks.
- Where PCA and epidural analgesia was being used the appropriate safety protocols were in place. For example, anti-emetic medication (effective against nausea and vomiting), reversal agent and fluids were also prescribed for use in the unlikely event of an emergency. Patients with these methods of pain relief also had the appropriate safety observations carried out regularly, for example, epidural block levels.
- There was no dedicated pain specialist nurse who provided support to patients and staff.

Nutrition and hydration

- There were effective systems in place to ensure that the risk of poor nutrition or dehydration was identified and managed on admission to the unit.
- We observed all the patients on the unit receiving suitable nutrition for their individual conditions.
- Nursing documentation demonstrated that patients had their fluid intake and output monitored continuously and the actions taken if an intervention was necessary.
- All patients had access to a dietician and speech and language therapist review should they require MDT input.

Patient outcomes

- KIMS was not identified as a CQC outlier. The term 'outlier' is used to describe a service that lies outside the expected range of performance.
- The medical records we reviewed during the inspection demonstrated that patients had their VTE risk assessed and addressed on admission. However minutes from the clinical effectiveness meeting in April acknowledged

that compliance rates needed to improve. Data we reviewed showed us that between January and July 2015 the department only achieved the >95% benchmark once.
- Data showed us that VTE screening rates fell below 95% in the 2nd, 3rd and 4th quarters of the reporting period (April 14 to March 15).
- The department was not participating in national audit programmes with the exception of the National Joint Registry. We must note the number of patients using the service at the time of inspection was very small. Therefore the dataset that could be provided to a national audit programme may not be sufficient at this time. There was a plan in place to participate in the national auditing programme once the organisation was running at full capacity.
- There was a surgical department audit programme in place at KIMS. Meeting minutes we viewed showed us that attendance at the new audit committee was low and the group was yet to determine terms of reference.
- The department did collect service quality data on a clinical score card. This monitored the quality of care being delivered. Data was provided for January to July 2015. There was no data for August and September.
- The RMO had recently started auditing surgical site infections in the department.
- Documentation audits had been implemented, for example VTE and cannula compliance.
- RCS standards for unscheduled care did not apply to this service as it only provided elective surgery. If an emergency occurred, the surgical on call team would provide support for the operating consultant and anaesthetist. This on call rota operated seven days a week.
- The department monitored surgical complication rates. Data showed us that some of the recorded cases had a documented investigation and recommendations. However, others did not.

Competent staff

- Staff were properly supported to provide care and treatment to patients. They were properly trained, supervised and appraised and encouraged to gain additional qualifications.
- However there was potential for staff to lose skills they had because they were caring for so few patients and some procedures were only undertaken on an occasional basis.
- The department undertook simulated staged emergency exercises. The purpose of these exercises was to evaluate the staff skills and identify any system errors within the emergency procedures. This reduced potential risk to the organisation with particular regard to the management of emergencies that occurred at night.
- Each consultant practising at Kent Institute of Medicine and Surgery requires a statement confirming their practice in this hospital and reporting incidents, complaints or concerns. Reporting of incidents, complaints or concerns is furnished by the Medical Director and supported by information from the governance team. If a serious incident takes place or a concern arises relating to a consultant with practising privileges, this is communicated by the hospital's Medical Director to the Responsible Officer in his/her NHS Trust. This is a two way process and the Medical Director also receives information from the NHS Trust Responsible Officer that may affect the consultant's practice in Kent Institute of Medicine and Surgery. We saw evidence that appraisals were undertaken in this core service. The department reported over 95% compliance rate.
- Data demonstrating the comparative outcomes by clinician was not being collected routinely.
- The department had not made preparations to support nursing staff with the new Nursing and Midwifery Council(NMC) revalidation process.
- The number of consultants with practicing privileges was excessive for the workload and meant many of those offered admitting rights were unfamiliar with the hospital, the provider policies and the equipment.

Multidisciplinary working

- It was evident that there was a functional multidisciplinary approach to the care delivered in the surgical department. The documents we reviewed and the staff we spoke with confirmed this.
- We observed physiotherapy and specialist nursing input into care during the inspection.
- There was a good working relationship between other departments in the hospital.
- The hospital had appropriate Service Level Agreements with local providers and external providers.
- However, there was a lack of information regarding multidisciplinary review in the medical records of some people who had surgery for the management of cancer.

Surgery

Seven-day services

- There was sufficient access to screening and diagnostic series 24 hours a day, seven days a week.
- The department had an on call response system out of hours. This included radiology, pharmacy and the theatre team.
- Physiotherapy, Speech and Language Therapy and Occupational Therapy was provided to KIMS by external providers on request.
- Consultants provided on-call cover for the duration of their patient's hospital stay.

Access to information

- We found the department provided information which supported patients and their relatives to make decisions about their care and treatment.
- Staff had ready access to necessary information about individual patients, hospital policies and professional guidance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed a large volume of medical records during the inspection. During this review we focused on the consent process. We did not identify any concerns with how consent was obtained.
- Where a patient was consented for a bariatric procedure, we found a very good standard of consent in operation. However, it is worth noting that the consent forms used for these procedures were provided by an external provider.
- During our review, we did identify one patient who required a translator. There was no evidence that one was provided when the consultant obtained consent. Consent was obtained on the same day as the procedure.
- Evidence of a best interest meeting was shared with CQC. This meant that staff recognised patients' individual needs and acted accordingly.
- KIMS had a Mental Capacity Assessment Policy in place. We did not see it in use during the inspection. However, staff were able to demonstrate adequate knowledge of procedures should they suspect a patients lacked capacity.

Are surgery services caring?

Good

We have judged the way services were delivered in the surgical department at KIMs to be good for caring because:

The verbal feedback from people who used the service, and those who are close to them was entirely positive. Some of the comments received were, "The staff are kind and efficient". They described the staff as making regular checks. Some patients said they felt safe.

Patients felt involved in planning their care and told us they received enough information about their conditions to be able make informed choices. We saw staff acting professionally when interacting with and involving patients in making decisions about their care. This meant that patients felt supported and involved in the care being delivered.

Relatives told us they felt the care delivered was in line with patients' medical needs and personal wishes. During the inspection staff were observed to be friendly, courteous and helpful towards patients, visitors and the inspection team.

We observed staff treat their patients and their loved ones with dignity, respect, compassion and empathy. Staff respected patient confidentiality.

Compassionate care

- We observed the staff on the unit being very kind, caring and compassionate towards their patients.
- The hospital reported consistently high (above 85%) Friends and Family Test scores for the reporting period October 2014 to March 2015. The FFT is a simple test that asks patients whether they would recommend the hospital to their friends and family.
- The patient survey did highlight that people felt rushed. Only 59% of patients felt they had enough time with the RMO.
- The patients we spoke to told us they were fully involved in planning their own care. They also told us they had enough time to ask question and discuss concerns with their consultants before surgery.
- Patients felt the care they received reflected their personal beliefs and that staff respected their wishes.
- The patients we talked with told us they felt safe and would happily recommend the service to others.

- Relatives we talked with were very happy with the way their needs were met during their loved ones' hospital stay.
- The surgical ward operated a named nurse systems. This meant that patients had a designated nurse as being responsible for a patient's nursing care during a hospital stay which promotes care continuity.
- KIMS monitored and responded to feedback on social media forums.

Emotional support

- Emotional support was mainly provided by the nursing staff on the ward.
- Support included reassurance from nursing and medical staff, and referrals to the appropriate professional.
- The hospital did not provide counselling services. However, referrals could be made to an external provider should the need arise.
- We found evidence during our notes review that patients had received psychological review prior to surgery, where appropriate.

Are surgery services responsive?

Good

We have judged the responsiveness of services delivered at KIMS to be good because:

Access and flow was good but the hospital was not operating to full capacity at the time of inspection.

Staff acted in patients' best interest and delivered an individualised service. They took into account patient's personal preferences and human rights. This meant that the service promoted person-centred care, promoted good health, wellbeing and independence.

The provider demonstrated that it promoted equality, and could meet the needs of people in vulnerable circumstances.

There was a good rehabilitation programme, in place which focused on supporting people to regain independence after surgery and prevent unnecessary readmissions.

The conversations we had with patients, relatives and staff indicated that patients were involved in decision-making about their care and choices available to them. They told us they had their spiritual and cultural needs were met whilst being an inpatient.

The department demonstrated a holistic approach to the care delivered. Staff were competent and met the individual care needs of the patients.

Service planning and delivery to meet the needs of local people

- The hospital responded to market forces and planned services that people wanted.
- The provider was working with local CCGs and NHS trusts to try an increase their occupancy rates whilst supporting attempts by the NHS locally to alleviate bed pressures and waiting lists.

Access and flow

- Patients could be admitted at a time that suited them. On the day of surgery they moved smoothly through the department and were either discharged following day surgery or accommodated on the ward. There were no delays during our visit. However, it is important to note that the hospital was not operating to full capacity at the time of inspection.
- We found 15% of theatre activity was fixed and 85% of the work carried out was subcontracted from NHS healthcare providers.
- Day case patients who required admission had immediate access to overnight facilities, should they require them.
- We did detect several incident forms that indicated surgical cancellation due to poor pre-assessment. These forms identified patients who were classified as having high morbidity due to their complex medical history. Patients attended KIMS for surgery without appropriate tests being carried out and had their surgery cancelled on the day of admission. An example of tests that were not carried out were ECG's (an electrocardiogram is a test that checks for problems with the electrical activity of your heart), routine bloods, anti-coagulant pre assessment guidance.
- A discharge pathway for patients was in use on the ward. This meant that staff could ensure that patients had all the relevant information they needed before their discharge.

- Electronic letters were sent to patients' GP's to ensure they were kept up to date on the individual's progress and post-operative care requirements.
- Patients' told us they were very happy with the care, but the discharge process "felt a bit rushed".
- Data we reviewed suggested three surgical cancellations between 1 June 2015 and the 30 June 2015.

Meeting people's individual needs

- People's individual needs were identified at pre-assessment, which meant that there was ample time to ensure extra measures were in place prior to admission. This might include larger beds or chairs for larger people, for example.
- The trust had a range of patient information leaflets available.
- We saw a wide range of condition specific information available for patients.
- Patients could request a specific surgeon or anaesthetist to carry out their procedures. This meant that individual patient preference was respected.
- Translation services were available if required.
- KIMS had a service level agreement with a local healthcare provider to ensure that patients with mental health issues could be appropriately cared for, should the need arise.
- Staff told us that they were able to provide one to one care for patients with learning difficulties if required. There were no specific communication tools in place for people with learning difficulties or dementia but the number of people requiring these were negligible.
- We observed staff deal with a patient with complex needs during the inspection and found their approach to be one of kindness and patience.
- There was no dementia training available for staff at KIMS. However, staff were able to demonstrate an understanding of the condition and their roles in ensuring that patients living with dementia had their care needs met.
- The theatre department had picture of key staff in the reception area. This meant that patients could identify specific members of staff who would be looking after them.

Learning from complaints and concerns

- There were effective systems in place to deal with comments and complaints, including providing patients with information about how to raise concerns or make a complaint.
- Patients and their relatives were supported to make comments and raise concerns.
- The patients and relatives we spoke with told us that they felt confident that any concerns they raised would be listened to and dealt with appropriately and were confident that they would not be discriminated against for raising concerns or making a complaint.
- Once the complaints process had been closed, patients were sent a questionnaire to ask how satisfied they were with the process.
- The surgical department received 28 complaints between August 2014 and September 2015. There were recorded on a spread sheet and had a recorded learning outcome documented. The complaints ranged from administrative errors, booking and billing concerns to the cancellation of a procedure.
- There was no evidence that consultants were involved in learning from complaints.
- During the inspection we identified complaints that were recorded as an incident rather than complaints. This may suggest that staff required clarification around the differences between incidents and complaints.

Are surgery services well-led?

Requires improvement

We have judged whether the surgical service at KIMS is well-led and rated them as requires improvement because:

The governance, risk and quality systems and processes in the department required further development. Policies and procedures were not up to date and a selection had been issued to staff without being ratified. The department had no oversight or quality assurance mechanisms to measure the service provision by external healthcare providers.

The hospital was not getting surgical safety right with low numbers of patients. There was a risk that as the occupancy levels increased the safety systems would not be adequate to ensure all patients were protected from harm.

Surgery

There was no positive evidence of the competence of consultants with practising privileges who did not have an NHS contract. Oversight of clinical practice was minimal.

However, the service had a vision and a strategy was being developed. Staff felt involved in the service development and in a position to influence the way changes were made. We found evidence of good local leadership on the ward and the theatre department. Staff had confidence in the clinical leads and hospital board. They described an open, transparent and supportive culture in the surgical department. There were systems in place that facilitated successful and on-going staff engagement.

It is acknowledged that the new CEO and governance lead had not been in post a sufficient length of time to make the necessary strategic and operational changes. It is because we could see they were clear of where they are taking the organisation that this domain. 'well-led' is not rated inadequate.

Vision, strategy, innovation and sustainability for this core service

- There was an appropriate vision for the surgical services. The new executive team were developing a strategy and knew where they wanted to take the organisation. The department was striving to develop and expand the service to improve capacity and improve efficiency. It was recognised that the organisation needed to get it right for routine, low risk patients before developing higher risk, more complex work.
- Staff felt encouraged to bring their ideas for service improvement to senior management and told us they felt involved in developing the services they worked in.

Governance, risk management and quality measurement for this core service

- The governance, risk and quality management function and structure required further development. This was most evident from the way that incidents were reviewed and learnt from.
- Staff undertaking RCAs did not have the appropriate training therefore the quality of the reviews and learning was affected.
- STEIS reporting was not as robust as it could be and the reporting criteria were not well understood.
- Audit practices had not been sufficiently developed across the department and the audit committee was not operational.
- Pharmacy audit did not reflect hospital policy.
- Several hospital policies required review and ratification.
- We found no evidence of oversight or quality assurance mechanisms to measure the service provision by external healthcare providers used at KIMS.
- The board had employed a new governance lead who had taken up post a week before the inspection.
- The department operated a risk register which reflected identified risks to the service.
- The hospital website advertised surgical procedures which could not be undertaken in the department. This could be perceived as misleading and confusing for prospective patients.
- The website also detailed critical care facilities that were only available on a planned basis. This was not made clear to patients who could make their choice of provider based on emergency facilities and support that would not be available to them, in case of an unexpected deterioration in their condition.

Leadership/culture of service related to this core service

- We found evidence of strong leadership and support for staff in the theatre department.
- Leadership in the ward areas was also found to be good. However, we acknowledged the challenge of having three managers in one ward area because the service was still being developed and the hospital was not operating near capacity. The team worked hard to ensure staff worked in a standardised and productive way.
- Staff also told us they could raise concerns in an open and transparent manner and felt confident they would be listened to. This was evidenced in the amount of incident forms we reviewed.
- Staff told us they raised concerns about inconsistencies in consultants' requirements. They confirmed that this was being addressed at a management level. This was an example of staff raising concerns and having their concerns addressed.
- Morale across the department appeared to be high and staff described a feeling of "great pride" working at KIMS.

Surgery

- Staff told us they had confidence in the immediate line managers and felt engaged with by the senior management team.
- Staff described their relationships with management as, “Respectful and amicable”.
- The staff we talked with felt their job made a difference and they were proud of the standard of care they delivered.
- The staff we talked with were found to be very open and transparent in their approach to the inspection process, which was indicative of a healthy culture in the department.
- The hospital ran a CEO breakfast forum. Staff were invited to join the CEO for a sit down meal and they take questions on any subject. Questions raised and answered at this breakfast were then shared with all staff through the team brief.
- There was also a clinical services circular newsletter distributed to staff to keep them up to date and well informed on important clinical matters.

Critical care

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

Information about the service

The Critical Care Unit (CCU) at the Kent Institute of Medicine and Surgery (KiMS) consists of two distinct, separate treatment areas. An intensive care unit (ICU) with four beds provides care and treatment for level three patients who require one-to-one nursing care. A high dependency unit (HDU) with three beds provides care and treatment for level two patients who need a higher intensity of care than can be provided on a general ward. The ICU has a direct link with the cardiac theatres. The HDU is located within a general medical ward. There is an isolation room in the HDU. Each bed space in the CCU operates on a 'barrier nursing' model that includes colour-coded aprons for staff. This is a method of working that protects patients and staff from infection risks by ensuring that each bed space is operated independently and staffed consistently by nurses who are not treating other patients at the same time.

The CCU cared for 13 patients between April 2015 and September 2015. The CCU has 24-hour seven-day consultant intensivist cover under an agreement with Medway NHS Foundation Trust. A consultant intensivist is a senior doctor with special training in treating critically ill patients. A critical care resident medical officer (RMO) is on site at all times and liaises with the lead consultant with regard to admissions and clinical decision-making.

The CCU accepted only planned, elective admissions at the time of our inspection due to low numbers of available staff. In the event of a patient becoming critically unwell in another department of the hospital and requiring level three CCU treatment, an emergency transfer plan would be implemented by the critical care RMO and lead nurse to move the patient to another hospital. This plan will be reviewed by senior management when the CCU is fully staffed and can accept unplanned admissions.

We spoke with three nurses, the lead consultant intensivist, a critical care RMO, an intensive care registered nurse who trained CCU nurses, a physiotherapist and a former patient and one of their relatives. The CCU had no patients during our inspection. We looked at ten incident reports as well as eight patient records and 30 other pieces of evidence.

Critical care

Summary of findings

It is important to point out that this section of the report relates to staff input rather than patient outcomes. There were no patients in the unit at the time of the inspection, so it is not possible to give a rating based on the care patients received. The inspection report is a narrative rather than a judgement against the ratings.

Overall we found that there were significant concerns identified by the inspection team. The concerns identified included staffing levels, the results of local audits and the potential for the reduction of nurse competencies due to lack of practice.

The CCU was empty during our inspection. Nursing staff were engaged with writing new policies and protocols in preparation for a future increase in patients and therefore failed to routinely practice critical competencies and skills. This lack of practice put staff at risk of losing critical competencies and skills. Although there was a programme in place to mitigate such losses, including the opportunity for staff to work supernumerary shifts in CCUs at other hospitals. We found that its processes were not structured or consistent enough for staff to be sure that their skills were maintained.

The CCU environment was clean, hygienic and well equipped. New equipment was in place and staff had been trained in its use. The lead nurse maintained documentary evidence that staff were adequately trained and assessed in the use of equipment.

A change in nursing staff rotas meant that the CCU could not accept emergency or unplanned admissions. A non-contractual system of flexible working was in place among the nursing staff that meant they were often under pressure to work excessively long hours. Consultant intensivists were available on a 24 hour rota, which sometimes breached Intensive Care Society (ICS) requirements as staff would also be on call for another hospital at the same time. Staff told us that the provision of adequate staffing levels was one of their main concerns about the service and the unit could not safely be opened for non-elective patients until more nurses were recruited.

An incident reporting procedure was in place and most incidents relating to the CCU occurred due to low staffing levels. Incident reports monitored by senior management contained inconsistent evidence that learning from incidents had taken place.

Experienced staff were in the process of establishing policies and protocols using national benchmarks and standards, including clinical guidance from the National Institute for Health and Care Excellence (NICE) and the British Association of Critical Care Nurses (BACCN).

The CCU was not contributing to national audits compiled by the Intensive Care National Audit and Research Centre (ICNARC) as the department was operating at a low capacity. Staff had begun to conduct small internal audits as preparation for future national versions.

Staff were passionate about building the capacity of the service and planning for its future success as a centre of excellence. The acting lead nurse for the department had undertaken work to ensure the team was robust, stable and coherent and a recruitment plan had been implemented to increase staffing levels and so accommodate greater capacity. The department was short of three full time nurses to meet the number considered safe for it to operate at full capacity.

Critical care

Are critical care services safe?

Not sufficient evidence to rate

Staffing levels were below the minimum requirement of Registered Nurses (RNs) for the unit to operate at capacity and there was evidence that working patterns had negatively affected patient safety.

Working pattern incidents included excessively long shifts and double shifts without time off. Incidents such as these had been reported and investigated but the provided evidence did not always show that learning had taken place or been disseminated.

Our review of 10 incident reports found that senior managers did not involve nursing staff in the root cause analysis or explore substantive changes of policy to ensure that working pattern incidents did not recur. As a result of incidents, nursing staff had been removed from a scheduled, mandatory on-call system and the unit had suspended its acceptance of unplanned, non-elective patient admissions. However, we found that an informal escalation process had been implemented by senior mangers that meant nursing staff could be called during their off-duty time and asked to attend work for an urgent patient. Nurses told us this process caused significant problems with work-life balance and that an expanded team was urgently needed.

There were frequent opportunities for training and staff were given access to these, including training in resuscitation and advanced life support. The CCU team was knowledgeable on safeguarding protocol and their responsibilities under the Duty of Candour.

Regular meetings between the RMO, nurses and consultants had taken place but staff told us that the dissemination of minutes was inconsistent. The National Early Warning Score (NEWS) system for deteriorating patients was used routinely and there were appropriate care bundles in place to ensure safe patient management. The CCU had lead consultant intensivist and critical care RMO cover 24 hours, seven days per week but this did not always adhere to ICS guidelines because the on-call consultant could be on-call for another hospital at the same time.

Incidents

- We found a culture of openness and transparency with regards to the reporting of incidents. Staff told us they were encouraged to report incidents as an opportunity for learning whilst the hospital became more established. Although staff told us that they felt learning had occurred from incidents, we could not find evidence that this had happened in practice in every case.
- The CCU had 10 incidents recorded in the year to our inspection. Collectively, the incidents indicated that a lack of a robust, consistent approach to staffing had prevented capacity from increasing and had added pressure to existing staff. We did not find evidence that learning from incidents had always taken place.
- One incident indicated that a CCU nurse had cared for a patient for 25 hours continuously and another report indicated that a CCU nurse had worked a day shift and consecutive night shift without a break. Another incident record indicated that staffing was too short to care safely for the number of patients in the CCU and that no additional staff were available. As a result the hospital's matron worked a clinical shift immediately after landing from an international trip.
- There was evidence that staffing levels had impacted on patient care and safety. For instance, whilst the adjacent medical ward was closed for redecoration, a patient had been booked into an HDU bed, leaving the unit isolated from other staff. The nurse on duty tried to alert four senior staff members but did not receive a response. One patient's planned HDU admission had been delayed and resulted in a transfer to another hospital because of low levels of nursing staff.
- The changes made to staff planning by managers had not addressed the problems identified in the incident reports. We did not find evidence that processes were in place to prevent a repetition of similar incidents happening again.
- The head nurse and critical care RMO had conducted a root cause analysis investigation following a serious incident involving a massive haemorrhage. This had led to a clearer, more robust communication plan for use during critical care treatment as well as increased o-negative blood stocks.
- We saw that after a needlestick injury involving a bank nurse, improvements had been made to guidance given to temporary staff by permanent CCU staff. For instance, new visual instructions on the safe use of cannulas were displayed in clinical areas and bank and agency staff were initially supervised when using these.

Critical care

- Staff we spoke with told us that learning from incidents was usually communicated by word of mouth with information on notice boards, which we saw happened in practice. Staff were able to discuss the Duty of Candour in detail and there was evidence from incident reports that patients or relatives had been involved in investigations.
- Mortality and Morbidity meetings had not routinely taken place. Monthly RMO meetings were used to discuss incidents and the outcomes of treatment such as transfusions. Staff told us that the minutes and outcomes of monthly medical advisory group meetings were poorly disseminated and demonstrated little learning from incidents.
- Resuscitation meetings took place every three months and were attended by the critical care RMO and resuscitation trainers from the hospital's training provider.

Safety thermometer

- There had been no falls, instances of pressure ulcers or urinary tract infections (UTIs) in the department.
- Risk assessments for venous thromboembolism (VTE) were in place and prophylaxes had been prescribed and administered appropriately. The critical care RMO completed bleeding risk assessments on admission and the lead nurse monitored this regularly. There were no audit data for VTE or UTIs due to the low number of patients.

Cleanliness, infection control and hygiene

- Housekeeping staff labelled cleaned and disinfected equipment with an 'I'm clean' sticker that also stated the date of cleaning. Nurses monitored weekly cleaning schedules for the ITU and HDU. If the unit had not been used by a patient then the records reflected this and a check was made by the head nurse to make sure cleaning stickers were in situ and that equipment had not been tampered with.
- A nurse had conducted monthly cleaning audits that indicated 100% compliance with nursing standards and 85% compliance in areas under the responsibility of the housekeeping team. The housekeeping manager and head nurse had taken action as a result, including new cleaning standards for low-level surfaces and extraction vents.
- A nurse had undertaken an infection prevention and control (IPC) audit in September 2015 in accordance with Infection Prevention Society and Department of Health 2011 guidance. This had resulted in improved practice, including the provision of hand held antibacterial gel toggles for staff accompanying transfer patients, reinforced requirements for completing sharps bin labels and a review of how often disposable bed curtains were changed.
- As there were no patients in the CCU during our inspection we could not observe IPC in practice during treatment. Each bed space was colour coded, this included nurses aprons and waste bins. Each bed space had it's own sink, glove stock and antibacterial hand gel.
- Although we could not observe patient care and treatment in practice, a standard operating practice was in place for the removal of catheters and the safe use of IV cannulas.
- There had been no reported instances of C.Diff, MRSA or blood stream infections.

Environment and equipment

- Staff had been trained to use specialist equipment in the department. This was recorded in equipment competency records and staff had been observed using the equipment before being recorded as proficient. Training had included Dinamap monitors, hoists, intravenous pumps, transport ventilators and Accu-Chek Performa systems.
- Resuscitation equipment was well maintained, easily accessible and had been checked regularly. The resuscitation lead nurse had conducted a resuscitation trolley quarterly audit between April – June 2015 and found equipment to be compliant with readiness and maintenance standards in all but one case. In this case, the nurse found a defibrillator in test mode and an electrocardiogram (ECG) dots pack had been left open. Action had been taken by the resuscitation lead nurse to ensure that resuscitation equipment was fit for purpose at any time.
- There was one resuscitation trolley in the CCU. Staff told us that the ICU and HDU would not be opened at the same time due to low levels of staffing and the resuscitation trolley would always be situated on the unit that was occupied.
- A nurse had audited cardiac arrest equipment in July 2015. There was 100% compliance with oxygen cylinder capacity, layout of emergency equipment, medication within its expiration date, regularly checked equipment and functioning portable suction devices.

- Service records for the equipment were available and met national standards for maintenance.

Medicines

- We looked at the storage of medicines in the CCU and found this to be safe, secure and compliant with NICE guidelines. Controlled drugs (CDs) were stored in a locked cupboard and documentation had been completed appropriately, including the recording of receipt, administration and disposal. A CD policy was in place and staff understood this in detail. Epidural drugs were stored and locked separately and IV drugs were stored and locked in a colour-coded unit.
- The temperature of fridges used to store medication had been recorded daily by a nurse and in all cases was within the safe storage threshold for refrigerated medicine.
- An antibiotic policy was in place and staff were able to tell us how they adhered to this.
- We looked at the care records of two patients and found that medication charts had been completed according to hospital policy.

Records

- We looked at the records of eight patients who had previously been treated in the ICU. Relevant medical professionals had completed the records appropriately. They included appropriate monitoring through completed observation charts, risk assessments, communication records, a nursing plan, fluid charts, a central line record and a cardiac pre-admission assessment where appropriate. In seven patient files, a consultant had completed a World Health Organisation critical care checklist. One file did not have this checklist and it was not clear why this was the case. Nurses had completed risk assessments for falls and bed rails and there was evidence that patients had been included in these.

Safeguarding

- All staff in the CCU had been trained to adult safeguarding level two and were able to discuss the department's policies relating to this in detail. Staff had a detailed appreciation of the impact of safeguarding in critical care and there was evidence that research had been undertaken to establish best practice approaches. There was an escalation plan in place for staff to summon expert help if they had a patient safeguarding concern, which could be implemented at any time. The sedation policy included a safeguarding assessment to ensure that staff did not override patient choice and ensured they were included in decision-making wherever possible.

Mandatory training

- We looked at the training and induction records for the three permanent members of nursing staff in the CCU. Each person had an induction 'passport' that was used to track and record their initial mandatory training. All three members of staff had up to date certification in the control of substances hazardous to health (COSHH), fire safety, medicines management and caring for people who were undergoing a blood transfusion.
- The Human Resources department managed mandatory training requirements and sent reminders to staff if their certification needed renewing. Some training was delivered using an e-learning system, which staff were positive about.
- The head nurse had arranged an annual study day had been arranged to ensure that mandatory training was up to date. Staff told us they had requested additional training from the hospital board of directors and that this had either been provided or arranged for a future date, such as a cardiothoracic 'Minicells' course and an ICU Acute Life Threatening Events: Recognition and Treatment (ALERT) course.

Assessing and responding to patient risk

- Staff had been trained in the use of the National Early Warning Score (NEWS) system for deteriorating patients. Cardiac arrest and deteriorating patient training had been delivered by AtoE trainers who had also conducted simulation exercises and unannounced drills to assess staff skills and response times. Trainers disseminated the outcomes of simulations to all hospital staff and where staff response was slow or inappropriate, this was escalated as a risk to be addressed by senior staff.
- An escalation policy was in place to move patients from level two to level three care if their condition deteriorated. However, as the CCU only had sufficient staff available to safely open one of the two units at the same time, a deteriorating patient would have to be transferred to another hospital if it was not possible to safely provide ICU care.

- A NEWS score of three or above, or a clinical suspicion of infection, triggered a sepsis care bundle that used the Royal College of Physicians (RCP) acute care toolkit for sepsis.

Nursing staffing

- A senior sister was acting up as head nurse at the time of our inspection and was supported by two senior staff nurses. The HDU was geographically part of a general medical ward and could use health care assistants from there to support with some care tasks.
- RNs in the CCU had completed an English National Board (ENB) for Nursing, Midwifery and Health Visiting ENB100 or equivalent intensive care course and an ENB415 or equivalent HDU course. Staff were also certified in basic, intermediate and advanced life support as well as paediatric intermediate life support and had undertaken competency training in haemofiltration and ventilation.
- The nursing team and senior managers had established the number of full time nurses needed to operate the CCU at capacity as 5.6 , three full time nurses less than those in post at the time of our inspection. Staff told us that they were preparing for increased capacity, which was being hindered by insufficient staffing levels to safely accept unplanned admissions.
- Staffing level policy met the guidance of the Intensive Care Society (ICS), which required one-to-one nursing care with a supernumerary nurse in charge for level three patients and nurse to patient ratio of 1:2 for HDU patients. Staff told us that although the policy was in place it was not always practiced because staffing levels did not meet the established minimum requirement.
- We saw that there had been instances where a 2:1 nurse to patient ratio had not been met. Agency nurses were used on occasion to supplement staffing levels and this usually meant that one agency nurse worked with one permanent nurse. Permanent staff had tried to secure consistency in the agency nurses that were assigned to the department by offering them training opportunities on study days, which they hoped would result in high levels of skill, competency and loyalty.
- We saw that on occasion, patients had been treated by one permanent member of staff and one agency member of staff. This breached ICS requirements that no more than 20% of clinical staff in a CCU be made up of agency staff but the 1:1 nature of such teams meant that the nurse in charge could supervise agency staff closely.
- A formal on-call system for nursing staff had been removed following concerns raised by staff that it led to them working dangerously long hours. Despite this staff told us that they were still unable to achieve a positive work-life balance because their new rota system operated on an informal on-call system. This meant that the critical care RMO or consultants could call nurses any time and ask them to work. This occurred because the department's patient flow was not always predictable and the total number of staff available was very low.
- One patient had been transferred directly from surgery to another hospital rather than taking up their planned HDU admission. This was due to the non-availability of staff. Although the incident had been investigated, we did not find evidence that appropriate safeguards had been put in place to prevent a recurrence.
- We found that because staff were not actively practising or developing their intensive care skills on a regular basis due to low patient numbers, there was a risk that core competencies could be reduced. To mitigate the risk, staff had undertaken supernumerary shifts in a cardiothoracic unit at another hospital and a relationship had been established with Medway NHS Foundation Trust CCU whereby staff could request supernumerary shifts under the supervision of a practice development nurse.
- We saw that an 'escalation tree' system was in place that the critical care RMO or nurses could use if a patient from a ward deteriorated and needed care in the unit at short notice. This meant that the senior member of staff on duty would try to secure extra nursing staff to be able to open the unit safely. If nurses were not able to attend, patients would be transferred as an emergency to an NHS hospital. Staff told us that on occasion they had felt pressured to work and this had led to them working up to 60 hours in one week.
- Senior managers, the head nurse and other permnanet nurses were involved in an active recruitment programme to increase nurse staffing levels. As a result, three bank nurses had been recruited and were awaiting clearance from the Disclosure Barring Service. More consistent agency nurses were also being sought, as was an extra sister. Staff told us that they hoped the process would ensure they always had two qualified nurses on shift per HDU patient, which would reduce their anxiety about staffing levels.

Critical care

- Staff had received specialised training appropriate to critical care. We saw that staff were certified in patient controlled epidural analgesia, medical gas administration and safety and the cardiac surgery advanced life support algorithm for postoperative cardiac patients. Staff had also been trained in cardiac emergency life support (CELS) and cardiothoracic advanced life support (ALS). The hospital had arranged specialist study sessions sin arterial and central lines.
- Training was provided by AtoE Training Solutions. We spoke with a trainer who told us that the organisation supplied training delivered by registered nurses who had experience of working in ITU and who were advanced life support (ALS) instructors certified by the Resuscitation Council (UK). Staff we spoke with told us that the training delivered by AtoE was specialised and of a high standard. Training was undertaken in the CCU environment using dedicated equipment and trainers also provided support for policy writing and audits. Trainers were able to offer nurses a 24-hour seven-day on-call support service.
- The permanent nurses in the CCU had designated link roles that covered ten specialties, including mental health, intermediate life support, blood transfusions and end of life care. Staff had also engaged with the British Association of Critical Care Nurses as part of their work to ensure policies and protocols were in place that followed established benchmark guidance, such as in the development of a weaning protocol.
- We did not observe a patient handover but there was a robust handover procedure documented that was used by nurses for the safe handover of patients when the unit was occupied.
- Staff were given time to research their own specialist areas of interest and present their findings during team days to help support the maintenance of skills and knowledge in the team.

Medical staffing

- The CCU was managed by four RMOs who were all supplied by an agency and who were all certified in ALSand paediatric advanced life support. RMOs told us that their annual appraisals and revalidations were completed by the agency.
- Anaesthetists and surgeons support RMOs in clinical decision-making.
- We saw from looking at training records that resuscitation and transfusion training had taken place involving simulated exercises using on-site equipment.
- A 24-hour seven-day consultant intensivist was available through a rota system shared between KiMS and Medway NHS Foundation Trust. Consultants were sometimes on call for both sites but as the CCU did not accept unplanned admissions, the risks associated with this had been mitigated. We were told that the consultant on-call cover required them to arrive on site within 30 minutes. We were unable to verify if this had happened in practice.
- Planned admissions usually occurred in the evening post-operatively, with an overnight stay and a planned discharge between 24 and 48 hours later.
- If a patient was deteriorating and had been identified as in need of an HDU bed, the consultant in charge would contact an intensivist and the decision would be made jointly to admit the patient.
- The RMO was responsible for the clinical support of agency and bank nurses, including the supervision of discharge checklists by temporary staff.
- The CCU RMO had a comprehensive and well-structured handbook that included lists of the policies relevant to their role as well as their expected responsibilities and behaviours. The training record of CCU RMOs was incomplete and it was not clear if all training had been fulfilled.
- When the CCU was occupied, morning handovers took place with the critical care RMO, the consultant intensivist and the nursing team. If there were no patients in the unit, a weekly handover would take place when the RMOs changed shifts.

Major incident awareness and training

- A major incident and evacuation plan was in place and all three CCU nursing staff were able to explain the procedure and their responsibilities in such an event. Their knowledge of emergency backup systems was very good. For instance, staff were aware of which equipment had independent electrical supplies and what the battery backup capability of each item was.
- An evacuation bag was available in the nurses station, which staff had been trained to use. It contained tube displacement for ventilation, IV lines and cardiac arrest drugs, which had been checked regularly for packaging and expiry dates. There was an evacuation lift available,

which staff had been trained to use in a vertical evacuation of the CCU. Each member of staff had undergone a walk-through of the evacuation procedure but had not received a simulated evacuation or drill.

Are critical care services effective?

Not sufficient evidence to rate

All nurses working in the CCU had completed a certified intensive care course and had up-to-date mandatory training, which meant that their clinical competencies had been assessed. Doctors working in the CCU all had practising privileges and were consultant intensivists with ICU experience. There was a focus on ensuring staff skills were maintained and developed through a programme of training that included modules such as paediatric life support and level two adult safeguarding. The department did not have its own practice development nurse or clinical educator and instead used a third-party company that had established a relationship with the needs of staff and provided structured and specialised support and guidance.

The CCU did not contribute to national ICNARC monitoring due to low patient numbers. In preparation for anticipated future capacity, staff had undertaken a number of small-scale local audits using practice benchmarks from the Nursing and Midwifery Council (NMC), the Resuscitation Council (UK) and NICE. The audits identified areas for improvement such as the need for every admitted patient to see a consultant intensivist within their first 12 hours on the unit.

Access to specialisms such as microbiology was available 24 hours, seven-days a week using a series of on-call systems for an out-of-hours service. Although a critical care outreach team (CCOT) was not in place, planning had begun in the form of CCOT policies and pathways based on ICS guidance. The provision of a CCOT service could be facilitated by the RMO if needed and staff established their skill competency base for this using guidance from the National Outreach Forum.

Staff had a good understanding of the principles of consent under the Mental Capacity Act (2005) and records we looked at indicated a consistent approach to obtaining patient consent before treatment was given.

Evidence-based care and treatment

- The CCU had not treated sufficient patients to contribute to national audits. In preparation for anticipated future growth of the service, the CCU resuscitation lead nurse had planned and undertaken local audits that used national guidance as a benchmark for their use. This had included an audit using the National Cardiac Arrest Audit tool and Resuscitation Council (UK) guidance on two peri-arrests. In both cases adverse event documentation had been completed and post-resuscitation care had been recorded although one record of peri-arrest was incomplete.
- The resuscitation lead nurse had completed an audit of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders using the guidance of the NMC. Compliance was found to be 81%. Problems found from the audit included a patient who did not have capacity, a patient with no valid advanced decision recorded and a patient with no appointed welfare attorney. The audit had been completed using Resuscitation Council (UK) 2015 recommended standards for the recording of decisions about DNACPR. The audit was due to be repeated every three months but staff told us that it was not clear if the physicians who were responsible for areas of non-compliance had been briefed on the requirements.
- A nurse had undertaken an observational audit using the data of 19 patients who had received an arterial line on-going high impact intervention from May 2015 to August 2015. There was 94% compliance with monitoring of the insertion site, circulation, hand hygiene and continued clinical indications. New consultant ward round documentation had been introduced as a result of this that included a time recording of the consultant review. In an audit of arterial insertion high impact interventions, a nurse found low compliance with the use of PPE at 57%, and 86% of lines were labelled. We did not find evidence that learning had been implemented or corrective action taken when non-compliance with PPE standards had been found.
- A nurse had conducted an audit of central venous catheter care bundles amongst 20 patients and found 100% compliance with hand hygiene, site inspection, catheter access, the use of clinically indicated dressings and catheter injection points.
- A nurse audit of the care bundle for ventilated patients included a check of the patient's head elevation, prophylaxis and tubing management. This audit

included only five patients and others included up to 20 patients. As such the percentages of the audits are not broadly indicative of care and treatment standards. However, staff had conducted the audits systematically and with adherence to accepted methodology so that as patient numbers increased, auditing processes were already established.

- A three monthly audit cycle was in place for arterial lines, central venous pressure, sepsis, total parenteral nutrition, tracheostomies and admissions records.
- The author of each audit distributed findings by e-mail to staff across the hospital for learning to be applied in each department. There was not a system in place for the lead member of staff in each audit to track who had read or acted on the results.
- The CCU had a resuscitation policy that had been produced by a senior CCU nurse in adherence with Resuscitation Council (UK) and European Resuscitation Council guidelines for best practice.
- A post cardiac arrest care bundle for comatose patients admitted to the ICU was in place. This followed Resuscitation Council (UK) 2010 guidelines and was compliant with the Intensive Care Society 2008 standards for the management of patients after cardiac arrest.
- The department had established its own operational policies and procedures and we saw that these adhered to NICE clinical guidance, including for intravenous fluid therapy, neutropenic sepsis, rehabilitation after critical illness and the care and treatment of patients with delirium.

Pain relief

- We spoke with a patient who had previously been treated in the HDU, about their pain relief. They told us that both epidural and oral pain relief had been provided when needed and that they felt this had been proactive and timely. Pain relief was offered in accordance with NICE guidance, including clinical guidance on the use of opioids in palliative care.
- Pharmacy cover was available 24-hours, seven-days per week and emergency pain control medication was available in the unit.

Nutrition and hydration

- In the records we looked at, a nurse or doctor used food and fluid charts to monitor HDU patients who were able to eat and drink. Nurses conducted a nutritional assessment using the Malnutrition Universal Screening Tool (MUST) and there was provision to order food and drinks from an on-site catering facility 24 hours a day, seven-days a week.
- The hospital did not have an on-site dietician but staff told us that they had access to a 24-hour on-call dietician at another hospital who was able to attend quickly or assess a patient remotely.
- Patients in the HDU were offered food as recommended by their consultant in accordance with a 'Little and often' policy. Staff were able to provide protein drinks, pureed food and culturally appropriate foods if needed.

Patient outcomes

- At the time of our inspection, there had been no cardiac arrests in the CCU and so the department had not contributed to national audits. The resuscitation lead nurse had undertaken a pilot audit on two peri-arrests in the hospital using the National Cardiac Arrest Audit tool as a guide. Peri-arrests describe abnormal heart rhythms that are known to be a precursor to a cardiac arrest.
- A nurse had audited the admission tool to identify the frequency of consultant intensivist contact with thirteen patients treated from April 2015 to September 2015. 85% of patients had seen a consultant intensivist within 12 hours of admission, 85% of patients had seen a consultant intensivist twice in their first 24 hours on the CCU and 92% of patients had undergone a full medical review twice per 24 hours of their stay. This left approximately 1:10 patients who were not reviewed by a consultant intensivist.
- Due to the low capacity of the unit, ICNARC data had not been collected. Staff were establishing protocols to be able to collect this in the future as patient numbers increased and staffing levels met the establishment. There was no readmission data available.

Competent staff

- CCU nurses had undertaken an evaluation of their supervised practice shifts. This helped them to evaluate their competence with support from the shift leader and included the identification of learning opportunities, the management of unexpected situations and the anticipation of problems. Staff had the opportunity to produce a self-reflection on the exercise, which we saw had been used to maintain motivation and morale by the senior nurse.

- The three nurses who staffed the unit were also involved in writing and updating standard operating procedures and disseminating this to others working in the department. This was accomplished through the use of a reader box. The nursing team had updated policies in whistleblowing, admission and discharge processes, adverse near-miss event reporting, needlestick immediate injury management and major haemorrhage protocol. Staff signed a recording sheet to confirm they had read and understood the policy.
- Nurses in the CCU were certified in adult critical care using the National Competency Framework and had received an appraisal in the year to our inspection. Staff had completed appraisals with a focus on skill and competence development and were proactive in contributing to the development of the service.
- To further mitigate the risks associated with the loss of clinical skills as a result of low patient flow, CCU nurses would share the care and treatment of ventilated patients. Staff told us that this enabled them to put into practice their observations and supervision during supernumerary shifts undertaken outside of KIMS.

Multidisciplinary working

- A dedicated critical care outreach team (CCOT) had not been established due to the low volume of patients. The nursing team and the RMO were able to offer the services of a CCOT when necessary and had begun to compile appropriate policies that adhered to ICS guidance and best practice guidance of the National Outreach Forum. This included the requirement that any staff undertaking CCOT duties be trained in the use of NEWS scores. A data collection process for patients after they left the HDU or ITU was in place, as part of a discharge protocol. Staff followed NICE acutely ill patients in hospital best practice and we were told that verbal handovers took place when patients were transferred to a ward.
- Microbiology and bio-chemistry services were available on site during daytime hours. Out of hours an on-call system was available provided by staff at Maidstone Hospital.
- A team of physiotherapists was available on demand and was provided by a third party company. CCU nurses told us that the physiotherapists had a lot of input into patient care and treatment and visited patients twice daily. From looking at patient notes we saw that physiotherapist input was documented and planned in the best interests of the patient.
- We saw that patients in ICU were treated by a multidisciplinary team depending on their condition. For instance, cardiac patients were cared for by a perfusionist, a cardiac intensivist, a surgical registrar, the CCU RMO and senior nurses. Such teams were provided on an ad-hoc basis and there was not an established or consistent multi-disciplinary team of clinical specialists. We saw that treatment plans were in place and that these were always discussed with the patient's consultant.

Seven-day services

- Microbiology, remote dietician input, bio-chemistry, phlebotomy, pharmacy and physiotherapy services were provided on a 24-hours seven-day basis. Consultants were on a 24-hour, seven-days rota and we saw that they had recorded weekend visits where necessary. There were established protocols in place to contact on-call staff in emergencies and from looking at patient records we saw that these worked well.

Access to information

- We looked at the transfer records of two patients who had been escorted by CCU staff in an ambulance to other hospitals. We found evidence that consent had been obtained for the transfers and that patients or their relatives understood the clinical need for this. Discharge documentation included details of the patient's treatment, pain score and the medication they had been given. There was not always evidence that the patient's GP had been contacted about their transfer or discharge.

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

- Staff had undertaken Deprivation of Liberty Safeguards (DoLS) legal training provided by a nearby clinical commissioning group. A senior nurse had also attended a level two MCA and DoLS conference and disseminated learning from it to other staff in the department.

Critical care

- In all of the patient notes we looked at there was evidence that patient consent to treatment had been obtained by the consultant. RMOs used the British Medical Association mental capacity tool to complete assessments with nursing support.

Are critical care services caring?

Not sufficient evidence to rate

We are not confident in rating the service on the caring domain as no patients used the CCU during our inspection. We were therefore unable to see evidence of caring in practice. Nurses in the unit were experienced in ICU environments and understood the need for compassion and sensitivity when talking with patients and their relatives. We obtained feedback from a former HDU patient and saw that a senior nurse had undertaken dignity champion training to help them support vulnerable people.

Understanding and involvement of patients and those close to them

- We spoke with a patient who had previously been cared for in the HDU. They told us that the nurses, consultant and RMO had kept them informed at each stage of their treatment and they felt they had been treated with kindness by staff who offered reassurance and information. A relative told us that they had been impressed with communication from staff.

Emotional support

- There was a designated dignity champion who was responsible for ensuring that department promoted people's independence and well-being by providing a high standard of individualised care and treatment. The post-holder had also disseminated information to staff on the importance of demonstrating emotional intelligence when working with critically ill patients. The member of staff had implemented 'knock before entering' stickers for disposable curtains to enhance patient privacy when in a bed bay.
- We did not see evidence that nurses had attended counselling courses at this hospital but staff told us that they had experience of this from their previous experience of working in critical care. The CCU did not have its own palliative care nurses, chaplain or psychologist but staff told us that such services were available on demand.

Are critical care services responsive?

Not sufficient evidence to rate

The CCU was being established within the hospital and had a low flow of patients. As such its scope to use knowledge from the local population to inform care and treatment planning and delivery was limited. Instead, staff worked towards care and treatment bundles and pathways that adhered to national guidance and benchmarks in preparation for future increased capacity.

There was provision for the unit to provide individualised care, including for patients with dementia, patients who did not speak English and patients who were unable to communicate verbally. The unit complied with ICS guidance with regard to policies for the transfer of patients. We found that there had been no out-of-hours transfers from the CCU. Where planned transfers had occurred and were clinically appropriate, staff used a robust transfer monitoring process to ensure patient safety.

A complaints procedure was in place and staff could explain to us how this worked in practice.

Service planning and delivery to meet the needs of local people

- Senior managers had suspended the provision to take unplanned admissions to the CCU due to low staffing levels of critical care nurses. This meant that only planned, elective admissions could be accepted. If a patient needed emergency CCU care elsewhere in the hospital, there was an unofficial process to follow to try and obtain safe staffing levels for to give the patient treatment on site.. However, in most instances the patient would be transferred out as an emergency by ambulance. Most of the patients who had used the CCU were cardiac patients and the staff team had undergone training to provide appropriate care for them.

Critical care

- Elective admissions were primarily cardiac patients and staff had ensured they were equipped to provide care and treatment that met the needs of such patients by undertaking cardiothoracic training and supernumerary shifts at an NHS hospital.

Meeting people's individual needs

- The department had a contract with Language Line, a live on-demand translation service. Staff were able to use this service at any time and would do so to avoid the safeguarding issues associated with allowing a relative to translate for someone receiving treatment. Nurses had access to visual communication prompts to help communicate with patients who were not able to do so verbally.
- There was a dedicated dignity champion in place in the CCU who had undertaken training in the care of people with dementia. The department had not treated any patients with dementia at the time of our inspection but a dementia care pathway was being developed.
- Staff could arrange for the needs of relatives to be met at short notice, such as through the provision of on-site accommodation and catering.
- The lead consultant, RMOs and CCU nurses had held monthly clinical effectiveness meetings. Staff used the meetings to assess patient risks and outcomes and to ensure clinical practice met national benchmark guidance.

Access and flow

- An appropriate transfer policy was in place that was compliant with ICS 2011 guidelines for the transport of the critically ill adult. The process included 10-minute observations by staff during a transfer and we saw that this had been recorded in practice when patients had been transferred to another provider. There had been no out of hours transfers.

Learning from complaints and concerns

- There was a complaints policy in place and staff were able to tell us how this worked in practice. We saw that there had been one complaint since the unit opened that had been investigated and responded to by the consultant in charge.

Are critical care services well-led?

Not sufficient evidence to rate

A senior nurse acted as the CCU lead after the departure of the previous manager. This member of staff had worked to stabilise the team through securing additional training and seeking opportunities for staff to attend other hospitals to maintain their specialist skills. Staff told us that the CCU was a supportive and very positive place to work as a result of the efforts of the interim lead nurse.

There was a drive to build the capacity of the service through robust policy and protocol development and staff used national benchmarks and clinical guidance to ensure best practice. There was a lack of oversight and management at a level above the interim lead nurse. The CCU was equipped and staffed to accept unplanned urgent admissions but was prevented from doing so due a lack of permanent nurses.

Although staff had been offered the opportunity to maintain their skill competencies by planning to attend another hospital in the near future, staff told us that this would be difficult logistically because there were so few of them in the CCU. There was a lack of substantive support for CCU staff from their senior team, who we found had been slow to respond to requests for support and intervention when concerns had been raised.

Vision and strategy for this service

- Staff in the department were focused on planning for future increased nursing provision and capacity by ensuring that policies and procedures were in place that met national benchmarks and guidance. Staff were supported by senior managers and clinicians to develop local audits that would prepare the service to contribute to national submissions when capacity increased.
- There was a coherent local vision internally to the department in which staff spoke about their work towards a fully-staffed centre of excellence in critical care.
- We did not find that the department had an awareness of a broader vision or strategy for the hospital as a whole.

Governance, risk management and quality measurement

- The resuscitation lead from the CCU had raised concerns with senior managers about the risks associated with the hospital's crash call system. This related to problems with the equipment including poor quality radio batteries and areas on site where mobile phones would not work. Senior managers had implemented mitigating strategies, such as twice daily crash-call tests, twice daily crash team briefs and new software for mobile phones. Improvements in network coverage and a new radio system were being implemented and due for completion in October 2015.
- CCU staff used a monthly clinical effectiveness meeting to discuss the escalation of local audit results to the hospital board. Monthly senior leadership meetings were also used to discuss incidents and problems with service delivery or quality. There was not a robust system in place to ensure that the items raised at such meetings were used to improve the service at an operational level. The minutes of monthly clinical effectiveness meetings indicated that the lead consultant intensivist for the CCU had not always been present.

Leadership of service

- Staff we spoke with told us that senior staff, including the RMOs, were approachable and accessible.
- There was a culture of openness in the service that encouraged staff to discuss their concerns and suggest improvements. For example, the removal of the nurses planned on-call system had resulted from staff concerns about the practice. Although staff said that they felt listened to, changes were not always positive, such as the on-call system that was replaced with an escalation policy that had not improved the work-life balance.
- The interim CCU manager was highly regarded by staff we spoke with and was working to establish the CCU as a safe and effective department. They had significant challenges including how to manage competence and morale of staff when the working pattern was typified by periods of no patient activity followed by periods of high intensity.

Culture within the service

- As the service was very new and had no patients at the time of our inspection, it was difficult to understand the culture of the service and how this impacted patients and staff in practice.
- The risk of staff losing critical skills because of low capacity was a key concern and although mitigating factors were in place, we did not find that senior staff supported CCU nurses consistently. For instance, recruitment for new staff was driven by CCU nurses but there was a lack of clarity around how the most suitable candidates would be selected. Additionally, although staff had the option to attend other CCUs as supernumerary nurses, the low level of staffing at KIMS made it difficult for them to take this up in practice.
- Staff were confident in approaching the matron and senior managers to raise concerns and requests and there was an inconsistent approach to responses to this. For instance, concerns about the crash call system had been raised over several months but staff told us action had been slow.
- There was a lack of feedback and clarity to staff over the outcomes of meetings and incident investigations.

Innovation, improvement and sustainability

- The focus of sustainability was on increasing the staff base so that the unit could operate with an established number of nurses and begin to accept unplanned admissions.
- The sustainability of current nurses was being maintained through a programme of intense specialist training with structured support on demand from qualified trainers. We found that although this supported staff to maintain knowledge and skills through simulations and practical training, the lack of frequent 'live' application was problematic, with an impact on staff morale and motivation.

Services for children and young people

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

Information about the service

The Kent Institute of Medicine and Surgery (KIMS) is a private hospital that provides care for both NHS funded and other funded adults and children and young people up to and including the age of 18. Children under 16 years of age were only seen within the outpatient and diagnostic imaging departments. However, young people aged 16-18 years had undergone surgery for minor orthopaedic procedures. Current services offered and provided to children and young people include diagnostic imaging, medical outpatient care, audiology, dermatology and sleep studies.

The hospital saw 9,000 patients within its outpatient department between April 2014 and March 2015. Out of these 184 were children or young people. However, the outpatient department has seen a steady increase in numbers of children attending over the past three months.

We visited all clinical areas where children and young people were seen; these included outpatients, diagnostic imaging, physiotherapy, the Dover dermatology clinic and Haversham ward (where sleep studies were performed). We visited Copperfield and Nickleby wards, both of which had taken young people over the age of 16 years post operatively. We also visited the operating theatres. We spoke with 20 members of staff including one resident medical officer (RMO). We spoke to four sets of parents of children, via the telephone, who had attended KIMS for outpatient appointments. No children were attending the hospital during our inspection which meant that we were unable to speak to them whilst they were on site.

The hospital has a full time sick children's nurse, one permanent part-time children's nurse and two other children's trained nurses on the bank. This ensured there was always an appropriately trained nurse available for consultations and to support children throughout their appointments.

Services for children and young people

Summary of findings

This report relates to an entirely outpatient based service and the ratings and narrative reflect this.

We rated the services for children and young people as Good overall. We rated services as good for being safe, responsive, caring and well led. We rated effective the domain as requiring improvement.

Children were seen in a bright, clean, purpose built, child friendly environment which had modern equipment and age appropriate facilities. Children were chaperoned throughout the outpatient department by appropriately trained children's nurses. All nurses within the hospital had received level two safeguarding training and those in direct contact with children had completed level three training. Care was being provided by competent, well trained staff in all areas inspected.

The parents we talked to spoke very highly of the service and care their children had received at KIMS hospital. There was good access and flow to children's services and increasing numbers of children were being seen. The hospital had employed a second children's trained nurse to cope with the increase in demand.

The leadership of the hospital was cohesive, transparent and visible to all staff members. The service had an open culture where incident reporting was actively encouraged and used for training to improve care. Staff and public engagement were sought via satisfaction surveys for staff, parents and children. However the leadership of the children's service lacked some key roles. There was a lack of senior oversight of the service from a paediatric or children's nursing perspective and whilst this did not impact significantly on the outpatient service offered, it did leave the service operating outside of national guidance for the care of children in the independent sector and safeguarding children.

Are services for children and young people safe?

Good

We rated this service as good for safety based on provision of outpatient services only. We were not assured that there are adequate arrangements for inpatient services. This was recognised by the provider and they had undertaken not to admit children until the appropriate arrangements were in place.

There were no serious incidents that related specifically to children.

Safeguarding arrangements were adequate.

There were child specific policies and procedures in place and known to staff.

However, paediatric defibrillator pads were not available in all clinical areas which meant the response to a child arrest could be delayed.

Incidents

- Between April 2014 and March 2015 there had been no "never events" (serious incidents that are wholly preventable). Nine serious incidents (SIRIs) had been recorded across the hospital none of which were related to children and young people.
- One minor incident reported related to a child who had been booked in for an appointment when the children's nurse was not available. The appointment was changed and as a consequence the booking policy and procedure changed. All appointments for children and young people were coordinated through and booked with the children's lead nurse. This has ensured the availability of appropriately trained children's nurse for every appointment.
- Learning from this has resulted in a change of policy. The outpatients department was involved in all bookings and follow up appointments in relation to this core service.
- All staff we spoke with knew how to report incidents and concerns. However, one member of staff told us that sometimes they felt their concerns had not been acted on.

Duty of Candour

Services for children and young people

- The 'Duty of Candour' regulation states that providers must be open and honest with service users and other relevant persons when things go wrong with care and treatment.
- The hospital had a duty of candour policy in place which had been discussed at the monthly Clinical Effectiveness meeting in July 2015. It was suggested that all staff should read and make themselves aware of duty of candour policy.
- Only 12 of the 20 clinical staff we spoke with knew about 'Duty of Candour' and could demonstrate knowledge of what this new regulation involved.
- Hospital managers told us that Duty of candour training had been introduced and was being rolled out across the hospital.
- We were unable to see evidence of its use as there were no serious clinical incidents relating to children and young people.

Cleanliness, infection control and hygiene

- There had been no incidence of Methicillin resistant staphylococcus aureus (MRSA), Methicillin sensitive staphylococcus aureus (MSSA) or clostridium difficile or (C diff) within any part of the hospital.
- All areas we visited were visually clean and free from dust.
- The hospital had an infection control lead nurse. We saw evidence that cleaning schedules were in place and had been completed.
- Water temperatures were sampled weekly for legionella precaution.
- Toys were cleaned after every use and the children's waiting area had a separate cleaning log that reflected this was being achieved.
- We saw equipment had "I am clean" stickers stating they had been clean and all were dated.
- The hospital undertook a hand hygiene audit for which the outpatient department scored 95% compliance.
- The availability of hand gel could have been more prominent. For example, there was a free standing hand gel on the main reception desk and on the outpatient desk. Further hand gel dispensers appeared limited in number and were not prominent throughout the hospital areas we visited.

Environment and equipment

- The hospital was 17 months old at the time of the inspection. It was a purpose built award winning facility for its design.
- The equipment within the hospital was all 'state of the art', for example we saw MRI compatible syringe drivers within the imaging department.
- Within the ear, nose and throat clinic (ENT) we saw child specific equipment with various sizes of ear connections for examining and looking inside children's ears.
- We undertook random checks on the resuscitation equipment and other equipment throughout the hospital and found it to be in good order and checked routinely.
- In outpatients all electrical equipment seen had been PAT tested and dated.
- Resuscitation equipment was available in most areas but only the Automated Defibrillating Device (AED)'s in the outpatient clinic and Dover dermatology clinic contained paediatric defibrillation pads. We noted that the paediatric grab bags were attached to some AED's which contained equipment such as age appropriate airways. They did not contain paediatric defibrillating pads. For the amount of children and young people currently seen this is adequate. However this is an area the hospital may wish to look at when planning future children's services.
- The imaging department accommodated children and young people for general x-rays, ultrasound and consultant-led MRI scans. We were told that KIMS do not currently undertake sedation on children and young people within the department.

Medicines

- Nursing staff do not dispense any paediatric medications from the outpatient department.
- Glucagon, which had been removed from the fridge and into the cupboard, had not had its expiry date adjusted.
- The drug cupboard contained unlicensed acetic acid (3%) & Lugol's iodine that had not been recorded. We were informed that currently children were not receiving dressings within the outpatient department and therefore would not come into contact with Iodine.

Records

- Only one set of paediatric records was available for us to view at the time of inspection. The set of notes viewed was comprehensively completed, legible, timed, dated and signed.

Services for children and young people

- We reviewed care records both on the electronic system and one set of children's notes. Records were detailed and easy to understand. The records we reviewed were in line with the Nursing and Midwifery Council guidance on record keeping.
- Consent had clearly been obtained and was comprehensive in content. Staff understood the national guidance about obtaining consent from children and young people.
- There was a risk register in outpatients. Every child seen in outpatients had a record of which consultant they saw, their age and who they were accompanied by. Children and young people were accompanied throughout their visit to the hospital and chaperoned by a children's nurse specialist to ensure their safety whilst within the hospital.

Safeguarding

- There were three safeguarding clinical leads based within the hospital, one with specific child focus. There was no named child safeguarding doctor.
- The arrangements did not meet the requirements for named professionals cited in the Intercollegiate document, 'Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (2014)'.
- The Named Doctor should be a consultant with higher professional training in paediatrics. They must be clinically active in the field of child protection as part of their clinical commitments.
- All staff had been required to complete on-line safeguarding training sessions to gain level two safeguarding for children and young people. The clinical staff that had direct contact with children were required to complete level three. We saw evidence via the outpatient departments training matrix that this had been achieved by 95% of nursing staff but not by other staff who saw children, such as radiographers.
- We also looked at the continued professional development (CPD) register for one of the two hospitals Resident Medical Officers (RMO) and saw that they had achieved level three safeguarding training.
- There were policies for safeguarding and domestic abuse which included Female Genital Mutilation (FGM). There were clear flow charts in place for reporting suspicions.
- No safeguarding concerns had been reported to the CQC in the last 12 months.

Mandatory training

- Training records and new and agency staff induction passports were seen and demonstrated that over 98% of staff had completed mandatory training.

Assessing and responding to patient risk

- One risk assessment tool included recording the name of the children and young people along with who attended with them.
- There was no Paediatric Early Warning System (PEWS) in place as children were only seen as outpatients.
- Systems were in place to mitigate against the risk of not having the relevant medical information available at all consultant clinics. Notes (NHS or GP) were obtained prior to the clinic. If there was a late booking or a patient added, the consultant was made aware that there were no medical notes available prior to the patient attendance and asked for a medical history during the consultation.
- Consultant Practicing Privileges (PP's) agreement outlined that notes must not leave the premises without permission. The permission to take notes off the site by anyone was granted only by exception or in an emergency.

Nursing staffing

- Kent Institute of Medicine and Surgery had developed a staffing policy by using best practice standards and reviewing the NICE safe staffing guidelines, with built-in key performance indicators (KPIs) aligned with the NICE guidelines.
- There were low sickness rates for nurses and care assistants working in outpatient departments.
- There were no vacancies for care assistants in outpatients and the staff turnover was low in this department.
- Hospital policy sets out responsibilities for each level of staff and incorporates a Red Amber and Green (RAG) tool with guidance on escalation if there are concerns regarding staffing levels.
- A senior nurse was on duty at all times and was supernumerary so that they were available to support teams, as needed. However, this did not meet the recommendations of the Royal College of Nursing who state there should be, "A senior children's nurse involved in the planning and development of children and young

people's service provision and should work in collaboration with the local NHS. (Caring for Children and Young People: Guidance for nurses working in the independent sector, 2014).

- The hospital used a daily tool to calculate staffing requirements. This included the level of patient dependency, hours of nursing on duty, as required by the patients and took into account staff management and training time.
- The full time equivalent (FTE) number of nurses working in the (outpatient department) in nurse roles, excluding children's nurses, equated to 4.40 FTE.

Medical staffing

- Within the outpatient department there were only visiting consultants with practicing privileges.
- There was no paediatric oversight of children being seen at KIMS. The RCPCH recommends that a named consultant paediatrician is involved to ensure good standards of practice are attained and maintained but this is not necessarily an expectation they will work at the hospital. (2011)
- The consultants seeing children were specialists in ENT, Ophthalmology, Dermatology and Orthopaedics.

Major incident awareness and training

- An external provider ran "Simulated emergency exercises" around various departments of the hospital on a two monthly basis. Resuscitation of children had not yet been included.
- All the staff we spoke with told us they were aware of the emergency evacuation procedure for the hospital. However only eight staff we spoke with had been aware of any major incident policy.

Are services for children and young people effective?

Not sufficient evidence to rate

We rated effective as requires improvement.

Nursing competencies were not being checked or assessed in a timely fashion by senior nursing staff. A junior member of staff told us that they had been asked to undertake procedures they were not trained for and did not feel competent to perform. This went against KIMS own "Care of Children" guidelines and policies.

There was a lack of a comprehensive, consistent hospital education and training plan however we were informed that a practice educator had been appointed. The children's nurse specialist had developed specific competencies for non-children's trained staff.

The hospital protocols for children at KIMS were based on NICE and relevant Royal College of Paediatrics and Child Health (RCPCH) guidelines. Local policies were written in line with these and had been kept up to date.

Evidence-based care and treatment

- Assessment and treatment given was in line with British and Irish Orthopaedic Society guidance.
- The data available for evaluation of evidence based care and treatment was limited because the provider only offered outpatient services and any outcomes would be evaluated following surgery at another hospital.

Pain relief

- No child or young person required or was given pain relief within the outpatient department.

Nutrition and hydration

- Children and parents had access to a drinks machine that was based within the outpatients department.
- Facilities were available for breastfeeding mothers.

Patient outcomes

- Data on patient outcomes for children and young people was very limited as the hospital only provided outpatient services for this cohort.
- The hospital had a comparison from HWA for their patient feedback comparing KIMS against 91 other hospitals across 11 providers from January to July 2015. KIMS scored above average in all 13 criteria that were assessed and came 1st for pain management and explanations and 2nd for attention from nurses. This was not specific to the children and young people's services but was hospital wide.
- The Outpatient and Diagnostic Imaging to date had not undertaken Patient Reported Outcome Measures (PROMS) to obtain long term data on patient outcomes.

Services for children and young people

Competent staff

- We were told that competencies were assessed by the senior children's nurse and the outpatient nurse manager. However three staff members within the outpatient department told us they had not had their competencies assessed within the last 12 months. Two members of staff told us that competencies they had gained at their previous hospitals had not been reassessed at KIMS.
- One member of staff told us that they had been asked to perform venepuncture on children which they were not trained for. This was against KIMS own policy on paediatric venepuncture which states all bloods should be taken by a suitably trained and assessed as competent, registered nurse (RN).
- Nursing competencies were not being fully assessed in a timely fashion by senior nursing staff. A junior staff member told us that they had been asked to undertake procedures they were not trained for and did not feel competent to perform. This went against KIMS own "Care of Children" guidelines and policies.
- There was a lack of a comprehensive, consistent hospital education and training plan however we were informed that a practice educator had been appointed.
- The children's nurse specialist had developed specific competencies for non-children's trained staff.
- As part of annual appraisal requirements, each consultant practising at KIMS required a statement confirming his/her practice in this hospital.
- The resident medical officers (RMOs) had to provide evidence their continuing professional development (CPD) and demonstrate that their competencies log was up to date with their employment agency before they were able to be employed at KIMS.
- All staff within the outpatient department received annual appraisals and monthly supervision sessions for which they were 100% compliant.

Multidisciplinary working (in relation to this core service)

- As children and young people were only seen in the outpatient department we were unable to see any no evidence of multidisciplinary team working.
- The hospital had service level agreements with external therapists. For example counsellors and physiotherapists.
- There was also evidence of good links with local NHS providers.

Seven-day services

- Children and young people could attend the outpatient department on evenings and weekends if booked into a clinic. Where consultants had arranged clinics the children's nurses would accommodate this within their shift pattern.
- The hospital had two RMOs that between them covered the hospital over the full 24 hour period.

Access to information

- Information leaflets were available on a number of health topics relating to paediatrics including asthma and bronchiolitis within the outpatient department.
- Information on how to access hospital services was available for people within clinical areas and on-line via the hospital web-page.
- All clinical areas had hospital policies and procedures available which were accessible to staff on the hospital's intranet.
- Staff found it difficult to access information on line as the WiFi did not automatically log in to the providers intranet and turned itself off in less than 30 minutes. Mobile phones were not supported by the network. This was being looked into as a matter of urgency by the hospital.

Consent

- We saw evidence of consent being obtained in the one set of children's notes available to us.
- The staff we spoke to had a sound understanding of the national guidance on seeking consent from children and young people.

Are services for children and young people caring?

Good

We rated this service good for caring. Although at the time of our inspection there were no children within the hospital or visiting the outpatient department, we contacted four sets of parents and have used their comments and the friends and family feedback to make our judgement. The feedback we received was entirely positive.

Services for children and young people

Compassionate care

- We did not observe care of any children or young people as there were none on site when we visited. One parent told us they thought their child had received compassionate care. The patient satisfaction survey (friends and family) test results were constantly positive with more than 85% of patients saying they would recommend the service to friends and family.

Understanding and involvement of patients and those close to them

- One mother told us that the "staff were brilliant throughout". Explaining that the staff stayed in the room throughout the consultation, entertaining her child so she could talk to the consultant. The consultant explained everything to the child in a friendly and child appropriate manner.
- Another parent told us they had received a phone call from the hospital informing them there was heavy traffic in the area so not to worry if they were late for their appointment. They were offered another appointment if they thought this would suit them better. The mother was extremely impressed by the caring and thoughtful attitude of the outpatient staff.
- When we asked parents what they thought of the service we got very positive feedback. For example one parent said "I wouldn't have changed anything. The doctor kept in touch via e-mail and I made a follow-up appointment there and then".
- Another parent told us "Staff and doctors interacted well. The doctor explained the dissemination of information form extremely well. I can't think of anything I would change as everything was fantastic. My child felt at ease throughout and we have asked for all our future appointments to be at KIMS".
- A parent told us that the staff had recognised their child's needs and had accommodated them well.

Emotional support

- There was always a quiet room available where people who had become upset could go and get emotional support. We saw an example of this where the staff had taken time to speak to a distressed relative.
- The hospital had access to two counsellors and staff had open and free access to them.

Are services for children and young people responsive?

Good

We rated the service as Good for being responsive. We saw clear evidence of the service being planned to meet the care needs of local children and their families. There was good access to the service for privately funded children and young people. However there were not enough NHS funded children being seen at the time of the inspection to comment on the waiting times for these. The trust had a clear complaints procedure for when things go wrong and complaints were acted on in a timely and appropriate fashion.

Service planning and delivery to meet the needs of local people

- The hospital had acquired service agreements with two nearby NHS trusts to take "choose and book" patients. The "choose and book" system enables parents to choose whether their child is treated or referred to an NHS or private hospital.
- KIMS has not received any items of feedback on the NHS choices website in the reporting period April 2014 to March 2015.
- The outpatient department has seen a steady increase in the numbers of children seen over the past three months.
- To meet this extra demand the hospital has employed a second part time permanent children's nurse to work opposite the full time children's nurse within the hospital.

Access and flow

- Children and young people could be referred to KIMS hospital in a number of ways, via their GP, Consultant or self-referral.
- There was good access and flow to the service with minimal waiting times for appointments across all speciality services being offered within the outpatient department and diagnostic imaging.

Meeting people's individual needs

- Staff reported there was access to a translation service via "language line" should this be required. The

departmental manager informed us of available information to support people with different languages and cultures. All leaflets seen were written in English. We were informed that information could be obtained in other languages on request.

- We were told by one children's nurse that all children who attend the outpatient department or diagnostic imaging are treated and assessed on an individual basis. Children who have special needs requirements were dealt with sensitively, with input from parents. We were given an example of staff asking what time of day suited the young person best, the child's likes and dislikes (all of which were recorded for future visits). This enabled the appointment to be as stress free as possible for the child and the parents.

Learning from complaints and concerns

- We were made aware of one complaint regarding a child who had arrived for an appointment and the children's nurse had not been informed and therefore was not on site. This had led to a change in policy and procedure. All appointments were now booked in conjunction with the paediatric nurse so that she could check her own availability to ensure an appropriately trained children's nurse was on duty to support the child throughout their appointment.
- Complaints were reviewed by the Clinical Effectiveness Committee on a monthly basis. This included an overview of all complaints received during the month, whether the complaint was upheld (if it has been closed) and any learning to be shared back with department staff and cascaded down.
- If the complaint has not been closed within the same month the information was carried over until it was closed. Compliments were not recorded formally at the time of our visit nor reported back to a group, however individual feedback was provided when letters were received. Additionally cards received were shared with the department staff.
- Following receipt of a complaint a handler was assigned by the Complaints Administrator. This was based on the primary/most significant topic within the complaint. The handler was then responsible for overseeing the investigation in full, liaising with other managers/staff in order to obtain recollection of event forms from all the staff involved. The handler then provided all of this information and documentation to the Matron, Director of Clinical Services or Complaints Administrator who reviewed the information. If anything is unclear the handler will be asked for clarification and prepare the response letter to all points raised in the complaint. All Stage one response letters came from either the Director of Clinical Services or Matron in their absence. The information provided by the handler (usually by email for a written chain) was retained by the Complaints Administrator and saved in the electronic complaint file.

Are services for children and young people well-led?

Good

We rated the service as Good for being well led.

The leadership of the service was cohesive, transparent and visible to all staff members. The service had an open culture where incident reporting was actively encouraged and used for training to improve care. Staff and public engagement are sought via satisfaction surveys for staff, parents and children. There was a clear vision and strategy and a plan for the future sustainability of the hospital which included the introduction of paediatric surgery. There was no designated paediatrician clinical lead with oversight of services for children. However, there was no named doctor for child safeguarding.

Vision, strategy, innovation and sustainability

- The hospital had a mission statement and values which had been refreshed by the new CEO. We were advised that more work was still to be done on the values in the coming year.
- The Mission and values appeared on the intranet so that they are visible to all. All staff were recruited with the values in mind and the first module on the Hospital Induction was on the values – "How important they are to us and how they impact on behaviours both internally and externally".
- Mission and Values Cards were being printed up to be distributed to all staff to go with their ID badges.

Governance, risk management and quality measurement for this core service

- The hospital board presentation told us "It is our goal that it is clear to everyone 'how we do things around

here' and we aspire to ensure that staff have the message that this is an organisation that is really trying, 'To put patients first in everything we do' which is our overriding vision statement".

- "KIMS Team Brief" was a communication tool to let all staff know what was happening across all of the hospital departments on a monthly basis and had an upward feedback session. Information from these meetings was fed back by departmental heads to staff at weekly meetings.
- There was no specific governance of children's services and no board level lead with oversight of the care of children.

Leadership/culture of service

- Staff told us that the managers had an open door policy and they felt well supported by them.
- All staff we spoke to could name the clinical managers on the board and told us they were a visible presence throughout the hospital.
- We observed a positive response to senior staff as we walked around the hospital.
- There was no named doctor for child safeguarding and the designated nurse was not qualified for the role.
- There was no lead paediatrician with oversight of services for children and young people.

Culture within the service

- KIMS was supportive of its staff. For example, they have run several wellbeing events e.g. a fitness trainer on site once a week was being trialled. They had run heart checks for staff alongside 'Lunch and Learn' sessions on how to manage stress.
- The provider had commenced an employee assistance programme where staff could ring a helpline that specialises in stress management. Staff family members could use the line too.

Public and staff engagement

- The KIMS appraisal scheme described excellent behaviours as being at the heart of the scheme.
- The hospital had a values champion scheme where staff could be awarded £25 if they were nominated by their colleagues as the champion that month.
- Hospital managers told us a staff opinion survey was planned for October 2015. We were advised the survey had been designed to provide an overview of how satisfied and engaged staff are with different aspects of their working environment.
- The KIMS staff forum 'KIMS Voice' had with staff representatives from each department and met once a month with the CEO, Chief Nurse and HR. Issues were brought from around the hospital and discussed and representatives took the solutions or more issues back to their teams for discussion and resolution.

Innovation, improvement and sustainability

- KIMS is seeking to gain external accreditation of its staff culture and standards and has applied for Bronze accreditation for Investors in People. KIMS is working with Maidstone Borough Council to gain National accreditation through Kent healthy business awards.
- KIMS had a clear strategy in place for extending children's services, with the aim to introduce paediatric surgery to the list of services currently offered at the hospital. Although theatre staff told us that they had been on training courses in readiness to take children and young people we feel there is more work to be done before this happens. The provider recognises this and has agreed to consult with CQC prior to commencing children's inpatient services.

Outpatients and diagnostic imaging

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

Information about the service

The Kent Institute of Medicine and Surgery (KIMS) offered outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up were required. The hospital offered and provided 30 different specialty clinics to patients, which included medical and surgical specialties, psychotherapy and pain management.

The diagnostic and imaging department carried out routine x-rays, Magnetic-Resonance Imaging (MRI), Computerised Tomography (CT), Nuclear Medicine (NM), mammography and ultrasound scans.

In the year April 2014 to 2015 there were 18,530 outpatient attendances. 10,701 were first appointments and 7,829 were follow-up appointments. In the same period, 5,119 patients attended the diagnostic and imaging departments.

During our inspection we visited all outpatient areas and diagnostic imaging areas. We spoke with 13 members of staff, including managers, registered nurses, health care assistants and allied health professionals. We spoke with 13 patients in outpatients and diagnostic imaging waiting areas.

Summary of findings

We rated the outpatient department as required improvement. We identified problems with the safety and leadership of the service.

Not all staff reported safety incidents and there was inconsistency with learning from incidents. One type of medicine was not stored as the instructions on the label advised. Patients received some medicines without complete instructions, which did not comply with best practice guidelines. There was no legal framework in place for a member of staff to give out medicine. An unregistered health professional held keys to the medicines cupboard. The outpatient manager did not know there needed to be a legal framework in order for nursing staff to administer medicines.

The premises were not compliant with national guidance on infection prevention and control measures. There were carpets fitted in clinical areas where procedures were undertaken. Not all staff complied with the Bare Below the Elbows initiative.

Storage of some patient records did not meet the standards of the Data Protection Act. Floor surfaces did not meet building standards for a clinical environment.

Staff treated patients with kindness, dignity, respect and behaved in a professional manner. We saw processes that enabled patients individual needs to be met.

Outpatients and diagnostic imaging

Some staff in outpatients did not follow best practise guidelines because they lacked knowledge to do so. However, the radiology department demonstrated clear knowledge of best practise and processes to measure this.

The outpatient clinic ran clinics during weekdays, evenings and at weekends. There was some variability in the recorded waiting times for NHS and private patients, because of the availability of consultants and patient choice. The radiology department provided flexibility with staff to support theatre services.

Despite extended hours for outpatient clinics and a low number of patients attending, there was a high number of cancelled appointments, including short notice cancellations.

There was a lack of data collection to inform service planning.

In outpatients staff did not always feel part of a team and some staff told us they felt isolated. There were not clear processes in place to always keep patients from harm.

It was recognised by the inspection team that the radiology department were providing a very good level of service and care to their patients. Staff in radiology felt part of a team and involved. In this department there were clear processes in place to keep patients from harm.

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as required improvement because:

Not all staff reported safety incidents. In addition to there was no clear process to show there was always learning from incidents in outpatients We found one type of medicine was not stored in accordance with advice on its label. Patients were given medicine without complete instructions, which did not comply with best practice guidelines. An unregistered health professional held keys to the medicines cupboard. We found some patient records were not being kept safe and secure in accordance with the Data Protection Act. We saw a number of floor surfaces that were inappropriate for a clinical environment. However: We found that in general the environment and equipment were in good order.

Incidents

- Staff used a paper based system to record incidents. Incident reports were stored in folders in a chronological order, which we saw. Some staff had confidence in reporting incidents; whilst others had uncertainty about what incidents they should and shouldn't report.
- In one outpatient area staff told us that no incidents had been reported in the last 6 months. We were told about an incident in which a patient had bled for longer than expected following a minor procedure. This event led to other patients in attendance being cancelled and rebooked. We were told this incident was not reported.
- Staff told us about another incident where keys to a machine were lost. As patients in attendance could not receive treatment they had to be cancelled. We were told this incident was not reported.
- Assurances could not be given that incidents were being reported appropriately. In addition to this some outpatient staff told us they did not receive regular feedback about incidents. We saw examples of outpatient meeting minutes templates which have a section titled incidents. Out of four examples we saw, one had this section completed. It was not clear that incidents were being discussed regularly in outpatient meetings. We requested examples of a root cause

analysis used to investigate an incident in the last year. We were told that in outpatients none had been done. This indicated no investigation had occurred and no cause identified.

- In radiology a radiation protection supervisor was available in the department to for radiology staff to discuss incidents relating to radiation. In addition to this, staff told us that the radiation protection advisor, although not on site , was easily contactable should advice be required for reportable incidents required under the Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2000. Some IR (ME) R incidents require notification to the Care Quality Commission (CQC) under regulation 4 (5). In the last year the radiology department made one notification. A root cause analysis investigation occurred and lessons were learned. For example, an employer procedure was developed to lower the possibility of a similar incident happening. We saw a copy of this employer procedure. However, this procedure had not been audited since implementation which could not give assurance that this would not happen again.
- Staff in the imaging department told us they received feedback about incidents and lessons learned at team meetings. We saw copies of the minutes of imaging team meetings which confirmed this. In addition to this, the imaging manager told us that incidents were discussed at a radiation protection committee, of which we saw the minutes.

Cleanliness, infection control and hygiene

- Overall we found that the Department of Health's "Code of Practice on the prevention and control of infections and related guidance" was complied with in outpatient and diagnostic imaging services. There were systems in place to reduce the risk and spread of infection. In addition to this there was a named nurse for infection control.
- Patients told us they thought the hospital was spotless. We saw that consulting rooms and treatment areas were clean, tidy and well presented. In the outpatients and diagnostic imaging areas we saw cleaning checklists were completed each day that the departments were open. There was no dust visible on high and low dusting in most of the areas we visited. However, in the Dover clinic there were some dead flies on the window sill in room 33. Staff told us this room was not used often, but was available if required. Equipment had been cleaned and had a green label marked accordingly with a date and time and signature. The most recent infection control audit for patient equipment completed in June, reported 88% compliance, which was greater than the target score.
- We saw personal protective equipment, hand washing basins and hand gel was available in treatment areas, Posters were positioned over hand washing basins which explained '5 steps to hand hygiene' in line with World Health Organisation guidance. We saw staff in clean uniforms, bare below the elbow and observed them washing their hands in line with this guidance before and after interacting with patients. The most recent hand washing audit we saw scored 98% for the assessment of individuals.
- Staff signed a label on sharps bins label which indicated the date it had been constructed and by who. We saw sharps bins available in treatment areas were sharps were used . This was in line with health and safety regulation 5 (1) d, which requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. In addition to this, a most recent sharps bin audit achieved a score of 82% which was greater than the target score.
- We saw carpets in the consulting rooms and were told that some clinical procedures occurred in theses rooms. This did not comply with the Department of Health (HBN) Health Building Note 00-09: Infection control in the built environment Hospital building note (3.82) which states that carpets should not be used as this area has a high probability of body fluid contamination. However, staff told us that most clinical procedures occurred in designated treatments rooms, which were not carpeted.
- We saw that waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with HTM 07-01, control of substance hazardous to health (COSHH) and Health and Safety at work regulations. In addition to this the most recent audit of waste handling at the hospital recorded a score of 88% which was greater than the target score.

Environment and equipment

- We saw spacious waiting areas in good decorative order in outpatients and diagnostic imaging. Patients we spoke with told us that they felt outpatient and diagnostic imaging services were clean and spacious.

- We looked at consumables in consulting rooms. In one of the rooms one dressing pack out of seven was out of date, which indicated that a regular check of expiry dates was not occurring. All equipment we saw was marked as having a portable appliance (PAT) test, giving assurance that electrical equipment was safe for use.
- In the Dover clinic, all lockable cupboards were locked. The trolley in the minor ops room was well maintained and all drugs and dressings were in date.
- We saw first aid boxes in clinical areas and offices and phone numbers for assistance for first aid were clearly visible.
- In all the treatment areas we visited, disposable curtains were used. They were all labelled with the date on which they were due to be changed which in all cases was within three months.
- We saw resuscitation trolleys in outpatients, diagnostic imaging and the Dover clinic. Records indicated that the trolleys were checked daily on days when clinics operated. All drawers had correct consumables and drugs in accordance with the check list. We saw all the Ambu bags were in date and All trolleys were clean and dust free. The automatic electrical defibrillator worked and suction equipment was in order. On one trolley there was no expiry date on the laryngoscope blade, which could not give assurance that it was in date. Of two intubation tubes available on one of the trolleys, one was out of date, indicating that regular checking of expiry dates was not occurring.
- We saw that in diagnostic imaging, there was access to CT and MRI and nuclear medicine via a key card access. Only authorised personnel had a key card.
- In diagnostic imaging the patient changing rooms had their own toilet facilities, which looked clean.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in all areas of diagnostic imaging we visited. We saw appropriate warning signs and lights outside of rooms in accordance with Ionising Radiation (Medical Exposure) Regulations, (IR (ME) R 2000). However, the sign for nuclear medicine was very small.
- We saw Equipment in diagnostic imaging was serviced regularly and service records were complete and in date for all diagnostic imaging equipment. The department received medical physics support from a local trust. There was also quality assurance of the machines being tested once a week. This indicated that the machines were working as they should. These mandatory checks were based on the Ionising Radiation R egulations 1999 and the Ionising Radiation (Medical Exposure) Regulations (IR (ME) R 2000).
- Lead coat and thyroid protectors were available in CT and lead coat protectors were available in theatres. The effectiveness of their protection was checked with an audit. The most recent audit we saw was November 2014.
- A recent health and safety audit in the imaging department identified no areas for concern.
- An environment agency report of the imaging department's compliance provided independent assurance that systems and processes were in place to maintain and minimise risk in the imaging department.

Medicines

- Nursing staff had no awareness of if there was a policy on medicine management or if there was a policy about who could give drugs. The hospital did have a medicines management policy and we saw copies were available in consultation rooms. The outpatient manager told there were no patient group directives (PGD's) in place. This did not comply with the hospital's medicines management policy. PGDs provide a legal framework that allows the supply and/or administration of a specified medicine, by a named, authorised, registered health professional. To give to a pre-defined group of patients needing prophylaxis or treatment for a condition described in the PGD. Without the need for a prescription or an instruction from a prescriber. The legislation for PGDs is included in The Human Medicines Regulations 2012.
- A health care assistant held the keys to access the medicines cupboard in one outpatient area. This was not in compliance to NICE guidelines MPG2 which state the patient group directives around medicines management should only be used by registered health professionals. This was also not in compliance with the hospital's medicine management policy, Section 9.13.4.
- Whilst a to take out (TTO) pack was available for one medicine for a specific clinic in outpatients, the clinic also supplied two other medicines for which a TTO pack was not available. This was not in line with the Medicines and Healthcare products Regulatory Authority (MHRA) best practice guidance on the labelling and packaging of medicines, 2012.

- Records were not kept for all unlicensed medicines. We found that although records were being kept for melatonin 5mg, none were being kept for acetic acid, Lugol's iodine and Monsel's solution. This was not in line with MHRA guidance of off-label or unlicensed use of medicine: prescriber's responsibilities, 2009. Advice for prescribers says the medicine prescribed should be recorded and, where common practice is not being followed, the reasons be given for prescribing the medicine. It also suggests the clinician may wish to record they had discussed the issue with the patient.
- We found that in outpatients some medicine was not stored in accordance with its summary of product characteristics. We saw that some medicine should have been stored in a refrigerator and it was being stored in cupboard.
- In diagnostic imaging we saw that keys to all lockable cupboards were labelled clearly and stored in a key safe. The key to the safe was in a lock box accessible with a code. The diagnostic imaging department did not hold controlled medicines.
- The nuclear medicine department had medicines delivered as and when required. Medicine is this department was stored in a locked cupboard and the key was stored in an unlocked drawer. The nuclear medicine area could only be accessed by key card to which only authorised staff had access. This gave extra security to the medicine cupboard. However, there was no spare key to the medicine cupboard, which meant the medicine could not be accessed if the key was lost.
- We saw certificates for staff from the administration of radioactive substances advisory committee (ASARC) in a folder within the nuclear medicine department. This indicated staff giving medicine in the radiology department were safe to do so.
- Patients in nuclear medicine injected with a radioactive substance whilst in the department were isolated in a separate waiting area with a dedicated toilet, demonstrating good practise. This prevented others from being exposed to radiation. The radiographer checked the toilet for traces of radiation at the end of every day and there were processes in place to deal with high levels, which gave assurance this was being monitored regularly.
- Nuclear Medicines sourced their radiopharmaceuticals from a unit holding a Manufacturer's License from the medicines healthcare products regulatory authority (MHRA). This provided independent assurance of the quality of nuclear medicines used at this hospital.

Records

- In an unlocked cupboard in the dirty utility room in the Dover clinic we saw there were three specimen books. The books were labelled 'Kings Hill' and were dated from 2010. The books contained the first and last names of patients, their dates of birth and details of the specimens taken. As neither the room nor the cupboard door were locked, patient information was not being kept safely and securely. This was not compliant with the Data Protection Act, 1998. Records for patients receiving ultraviolet radiation (UVB) were kept on site for an unlimited amount of time. They were stored in a lockable drawer which was locked at the time of our inspection. This indicated that records were being kept securely in this area.
- We saw the medical records of six patients. There was no system in the records of alerting another medical professional, for example to allergies, which could mean that a significant medical problem could go unnoticed. The records were stored in a locked cupboard in a locked room behind reception, which gave assurance they were being stored securely. All notes were legible, dated and signed, which was in accordance with the hospitals documentation policy.
- A diagnostic request could be sent to the hospital via email or on paper. Staff told us a paper referral would be scanned into the computer then shredded. We saw that confidential waste was stored in a separate room in a locked office and was shredded on site. All patient paperwork was stored in a locked cupboard, providing assurance that records were kept safely and securely.
- The computer systems were secure and accessed by staff with individual log on details. Staff in radiology told us there were issues with incompatibility of two computer systems, but this was logged on the risk register, which we saw and was in the process of being addressed at the tie of inspection.

Safeguarding

- We were told that a children's nurse attended the clinic when children arrived. We were told about an incident

where one member of staff was seen tickling a child and another member of staff felt this was inappropriate. It was discussed with the outpatient manager but no incident was raised or safeguarding discussions had.
- All staff in diagnostic imaging had received training in safeguarding level one and two. Heath care professionals who interact with children should also have level 3 training, in relation to the Safeguarding Vulnerable Groups Act 2006. Training for staff interacting with children was not in accordance with the royal college of paediatric child health guidance (2010).

Mandatory training

- Staff in outpatients and diagnostic imaging told us they were up to date with their mandatory training. We saw copies of certificates of completion of mandatory training and a spread sheet with details of mandatory training. In addition to this we were told that the human resources team email staff if they were out of date with any of their mandatory training.
- Staff had passbooks which detailed the courses they had attended and the review date for updating. This information was also available on the intranet.

Assessing and responding to patient risk

- In a health and safety audit completed in January 2015 it was identified that there were no risk assessments done in outpatients. The outpatient manager told us risk assessments had been done for every room in outpatients and we saw copies of these. However, there were no environment risk assessments completed in the Dover clinic. There was no assurance patients were being prevented from harm.
- Nursing staff were aware of a lone working and security policy and told us that when late clinics were operating, they were provided with a mobile phone and panic alarm. We saw a copy of the lone working policy.
- Staff we spoke to were not aware of a policy on the management of an acutely unwell patient, but told us they would react in an appropriate way for a nurse. They told us they thought a patient would be referred to another hospital if that was required.
- Staff in imaging told us there had been a recent practice run for a patient in cardiac arrest. We saw a copy of the report on the simulation exercise and it concluded that in MRI there was low risk of harm to patients, because of the good response of the team.
- In the imaging department staff told us a patient MRI safety questionnaire was completed on the telephone prior to offering a patient appointment. This was then repeated at the patient's attendance to a diagnostic test and before the scan was performed, giving assurances that the risk to patients was mitigated, which is good practice
- Staff in radiology told us they would first check with a patient if they had previous scans and x-rays. They told us they were able to access any previous scan which enabled them to ensure a patient wasn't over irradiated, in accordance with IR (ME) R regulations. We saw the hospital's employers' procedure which confirmed this was the process.
- Staff told us they would not book patients in for a CT or MRI if they required a contrast media without having blood test results available. This was to minimise the risk of contrast induced nephropathy. We saw the hospital's employers' procedure, which was in line with the standards of the Royal College of Radiographers, prevention of contrast induced acute kidney injury in adult patients
- We saw that in nuclear medicine there was no visible sign to inform women of childbearing age to consider whether they may be pregnant. The sign was located in a drawer in the room where the Radionuclides were injected into patients. The hospital's policy required imaging staff to question a female of child bearing age with regards to the possibility of pregnancy and sign a form to confirm this which mitigated the risk in this patient group.
- Comprehensive policies and procedures available and in place in the imaging department. This was in accordance with the radiation protection advisor audit which concluded that the overall management of radiation protection in the department was found to be at a high level.

Nursing staffing

- Clinics had run for the last 6 months with less than the required establishment of nursing staff. This was because the outpatient nursing establishment was down by one whole time equivalent member of staff but was managed by the rota. The manager told us that staff and rotas were flexed to cope with clinics that were scheduled at late notice. Agency staff were never used

and over the past 6 months and 8% of staff were bank staff. Staff in Dover clinic told us no cover was provided if they were on leave which impacted on patients receiving their treatment.

Diagnostic imaging staffing

- At the time of our inspection, the imaging manager told us the department was short of six whole time equivalents, but a recent recruitment drive should address the short fall. Until then regular agency staff were being used. To provide a 24 hour service radiographers were on an on-call rota.

Medical staffing

- There was no on call rota for radiology consultants. If a radiologist was required, staff told us someone had to ring round to find one. This meant there could be a delay in patients getting their results.

Major incident awareness and training

- Several staff in outpatients had no awareness of a major incident policy or what a major incident or adverse event was. However, other staff were aware that cards were available to inform them what to do in the event of a major incident. They told us that there had been no drill for a major incident.
- In radiology there was an activity resumption plan which linked into a business continuity plan. Simulated emergencies occurred regularly around the hospital and we saw records of the analysis of these.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Some staff in outpatients had no awareness of the best practise guidelines for treatment they should be following. In addition to this, best practise guidelines relating to medicines management were not being followed. The radiology department had undertaken local audits and there was a plan of clinical audits to be undertaken. There was evidence of good team working in clinics and the radiology departments. In addition to this, clinics ran in the in the evenings and at weekends.

Evidence-based care and treatment

- The outpatient manager told us no auditing was undertaken in the Dover clinic and staff told us they had no awareness if there were guidelines for the use of ultraviolet radiation (UVB). The National Institute of Clinical Excellence (NICE) guidelines CG 153 give guidance on the use of UVB in psoriasis. The manager was unaware her staff did not know of the guidelines.
- NICE guideline MPG 2 was not being adhered to as there were no patient group directives in place for the issuing of medicines by nurses.
- Staff in outpatients and diagnostic imaging had a good awareness of and had read local policies. We saw copies of signed sheets indicating that policies had been read recently.
- The management of linen, sharps and waste was audited regularly. We saw copies of these and action plans arising from them.
- The imaging department had comprehensive policies and procedures in place. We saw these were in date, in line with regulations under IR (ME) R and in accordance with the Royal College of Radiographers' standards.

Nutrition and hydration

- Staff told us that if a patient attended an appointment after required fasting, they would be offered a drink and a snack following their treatment.

Pain relief

- Pain relief was not managed in the radiology department, but staff told us they could contact the resident medical officer to administer drugs if necessary.

Patient outcomes

- There was no use of patient reported outcome measures in the outpatient department at the time of our inspection.

Competent staff

- Some staff in outpatients didn't check whether a consultant had practising privileges. Instead they relied on a management system to check on competencies of attending doctors. Staff told us any issues arising from a doctor's competency would be discussed with the outpatient manager. The outpatient manager didn't feel she would be able to challenge a doctor if there were

concerns about their practice. This meant there was a potential patients were at risk of receiving treatment from consultants who may not have the competence or experience to deliver it.

- In the outpatients department we saw that staff had passbooks, which contained evidence of competencies. Mandatory training was up to date in outpatients and diagnostic imaging. In addition to this staff told us external training opportunities were available to them. We saw spread sheets indicating appraisals were up to date, but some staff told us there was no written documentation of this.
- In the radiology department we saw competencies for all agency staff who worked in radiology and the manager told us they used the same agency staff on a regular basis. In addition to this we saw cannulation records for those staff able to put a cannula in patients, providing assurance they were competent to do so.
- In addition to human resources checks, the imaging manager checked the registration of her staff with the health care professions council.
- In radiology, in compliance with IR (ME) R regulations, certificates were held for all staff in the hospital who were able to refer patients for diagnostic imaging tests. This gave assurance that only those qualified to request a diagnostic examination were able to do so.

Multidisciplinary working

- The radiology department was unable to offer a one stop breast clinic screening service as the national guidelines for breast screening could not be met. National guidelines required mammograms to be reported on in a timely manner, which the hospital was unable to achieve consistently.
- Staff communicated well between different staff groups within the outpatient and imaging departments.

Seven-day services

- The outpatient department did not provide seven day services.
- The radiology department provided a 24 hour a day, seven day a week service for urgent examination requests.

Access to information

- Staff accessed pathology test results electronically and in addition to this, the pathology department sent paper copies to consultants. Timely access to test results, assisted staff to make appropriate decisions about a patients care.
- Storage of records for patients receiving UVB treatments was safe and secure. Staff kept these records for an unlimited amount of time.
- Staff accessed patient information via a secure computer system, Those requiring access had individual passcodes.. In addition to this, administration staff had access codes to enable them to follow an individual patient pathway.
- Images from other hospitals could be accessed via a secure computer network in the radiology department. Staff could see what previous scans or tests had been undertaken. This enabled staff to ensure patients did not receive greater doses of radiation than required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Deprivation of liberty safeguards training was given to staff in diagnostic imaging. In addition to this they described the process of consent should a patient with a mental capacity issue be referred for diagnostic imaging test.

Are outpatients and diagnostic imaging services caring?

Good

We rated the Outpatients and diagnostic imaging services at KIMS Good overall for caring.

Patient satisfaction surveys were positive with all but one response rating outpatients as very good or excellent. We saw staff treating patients professionally with kindness, dignity and respect. Staff kept patients well informed prior to their treatment and a variety of helpful information was available in an age appropriate format.

Compassionate care

- Staff treated patients with kindness, dignity and respect. Staff interacted with patients in staff a positive,

professional and informative manner. The most recent patient satisfaction survey (April to September 2015) had 30 responses and 29 of those patients rated outpatients as excellent or very good.
- Re-arrangement of the mammography examination room provided a changing cubicle for patients undergoing an investigation. This prevented them from having to wait outside in a gown and respected their dignity.
- Signs on walls of the consulting rooms offered patients a chaperone if required. In addition to this reception staff asked patients if they would require a chaperone on booking in. This was in accordance with the Chaperone policy which we saw. Male and female staff acted as chaperones for patients, giving patients a choice in accordance with their preferences.
- Free tea and coffee was available to patients in the outpatient and diagnostic imaging waiting areas.

Understanding and involvement of patients and those close to them

- Clear and concise information was provided to patients prior to their appointment. They told us the reception staff treated them with kindness.
- Patients had access to a variety of information leaflets in diagnostic imaging and outpatient departments. Information was available specifically for children, older people and those with learning difficulties.

Emotional support

No evidence gathered to demonstrate this.

Are outpatients and diagnostic imaging services responsive?

Requires improvement

We rated outpatient and diagnostic imaging services at KIMS as requires improvement because:

Outpatient ran clinics on weekdays, some evenings and on Saturday mornings. Recorded waiting times varied for NHS and private patients, because of the availability of consultants and patient choice. There were high numbers of cancelled appointments and clinics cancelled at less that six weeks notice.

There was discrepancy between what the hospital management told us about same or next day appointments being available and what the staff and patient records showed.

Accurate data collection and analysis was not being used for effective service planning.

The radiology department was able to provide flexibility in staff to support theatre services.

Service planning and delivery to meet the needs of local people

- The consultants advised which clinics suited their availability following discussions with the marketing manager. This information was then sent to the outpatient staff to book patients. The clinic list was then shared with staff two days prior to the clinic.
- Receptionists booked patients in using a computer system which allowed the reception team to track them around the hospital. If there was a clinic delay of longer than 15 minutes, the reception team informed patients of the delay.
- At the time of our inspection the number of cancelled clinics or clinics overrun time was not being monitored. Staff intended to monitor this and take the information to the secretaries' forum. We saw 728 appointments were cancelled in the outpatient clinics last year, 538 by the hospital. In addition to this 62 clinics were cancelled with less than 6 weeks' notice.
- In the dermatology clinic, the clinic list was cancelled, if a member of staff was on leave. This did not demonstrate effective planning to meet the needs of people.
- The radiology manager described how she was able to flex staffing, so the department could provide support to theatres. The four day booking rule for theatres enabled the imaging department to review staffing levels to free a member of staff to attend theatre. In addition to this, we were given examples of how the radiology department standard opening times were altered in accordance with fewer patients over a holiday period.
- At the time of our inspection no radiologist was available on call, which meant staff had to ring round to find one. In order to provide more consistent reporting times, the radiology manager was in the process of outsourcing the reporting of diagnostic tests.
- The pathology service was provided by an external agency. There was no service level agreement in place

but there was a memorandum of understanding. There was also support from a local trust. Phlebotomy services were provided within the hospital and histopathology was outsourced; frozen samples were sent to a local trust for analysis.

Access and flow

- Most of the patients we spoke with had never been kept waiting for an appointment; others told us that if they had to wait, the reception team informed them of the wait.
- The hospital had recently started to see patients using the NHS 'choose and book' system. The first patient to be seen using this system was attending at the time of our inspection. There was a system in place to identify whether a patient fitted the choose and book criteria and if they did not an explanation would be given as to why not. We saw a copy of the criteria.

Meeting people's individual needs

- The recorded average waiting time for an outpatient appointment was 29 days, which was not consistent with staff telling us that appointments were available the same and next day. We saw records that reported the longest wait was in cardiology at 68 days. In addition to this we saw records that reported the shortest was audiology at 14 days. These figures were inconsistent with the information provided by the hospital.
- The average waiting time for diagnostic tests was reported to be 17 days. The longest wait was for ultrasound clinic at 36 and X-ray at 32 days, although the imaging manager told us some of those delays were due to patient choice. The capacity in the department was such that a diagnostic test could be offered the same day or next day. There were sometimes delays with vetting requests and due to the need for a patient to have a blood test prior to other examinations.
- Some consultants received paper referrals, others received them electronically. There was variation in the time it took from receipt of referral to booking of patients in the radiology department. This was dependent on the type of test required. A protocol was followed for some diagnostic tests and this required additional information prior to the test being booked. This in turn was dependent on a consultant being available to review the request. At the time of inspection, the amount of time this took was not being evaluated.
- Some information leaflets in outpatients and diagnostic imaging had been adapted for patients with learning difficulties, children and older persons. Although we did not see leaflets available in other languages, staff told us they were available, if required. In addition staff told us language line was available for translation. Staff gave an example where they had identified the need to use the translation service prior to a patient attending their appointment. They had practised using the language line prior to the patient's attendance.
- We were told of examples where consultants had seen patients at short notice at the patient's request.
- In radiology two members of staff had devised a series of flash cards with pictures of positioning of patients for use in the future. They were dementia and dignity champions.
- Male and female staff could act as chaperones in outpatients and the imaging department. This would meet the preferences of individual patients.
- In the last year, 365 evening clinics and 156 weekend clinics ran, offering patients a variety of appointment times and days.
- Patients had a choice of appointment time and day in diagnostic imaging department, five days a week.

Learning from complaints and concerns

- Staff in the outpatient department would not handle complaints at a local level, but would refer patients onto a governance lead.
- In the diagnostic imaging department information leaflets were available in waiting areas informing patients how to complain.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement because:

It was not clear there was regular feedback and learning from incidents, risk management or identifying areas for improvement in the outpatient departments. Some staff did not feel included in the team and felt isolated from others. However: In the radiology department we found

that staff were felt involved in decision making and were part of a hospital wide team. The was clear learning from incidents, which was shared in the local team and the hospital wide team.

Vision and strategy for this service

- The hospital had aspirations for improvement and expansion within outpatients. They were providing a wide range of specialty clinics available to patients at the time of inspection. Many of the services advertised on their website were not currently available but were in the process of being developed.

Governance, risk management and quality measurement

- The outpatients department kept handwritten minutes of their meetings and it wasn't clear that there was a regular agenda of feedback and learning from incidents, risk management or identifying areas for improvement. In addition there were examples of crossing through errors without initialling them which did not adhere to the hospitals documentation policy. In contrast to this, the minutes of radiology meetings demonstrated clear and regular review of incidents and complaints.
- Staff told us daily bed meetings occurred where capacity was discussed and planning for theatre could be considered. In addition to this there were regular department meetings in outpatients and diagnostic imaging. We saw copies of the minutes of these meetings.
- There were regular heads of department meetings where complaints and incidents were discussed .We saw the minutes of these meetings

Leadership and culture of service

- Some staff in outpatients felt remote from others in the team and did not attend regular department meetings. They did not think the executive team were visible. Other staff told us immediate managers were approachable and supportive, but felt communication could be better. The outpatient manager was unaware of staff not knowing NICE guidelines at the time of our inspection, but felt they should.
- In the radiology department there was a real sense of all staff working together as a team. The manager told us she was inclusive of all staff and gave an example where she encouraged staff to discuss and plan their own on call rotas. Several staff told us they felt involved and included in the decision making processes. The radiology department staff were knowledgeable about the senior management team and the vision of the hospital.
- Staff received regular email communications about leavers and new starters from human resources, which kept them informed of staff changes in the rest of the hospital.

Public and staff engagement

- Some staff in outpatients felt communication could be better and didn't feel involved in the business strategy. Other staff weren't informed of which clinics were being undertaken on which days, however other staff were aware of clinic bookings two days in advance of the clinic.
- A confidential employee assistance programme was available to staff, this was a telephone advice line to which all staff had access.
- We saw minutes of a patient participation group, with action points arising, but there had only been one meeting at the time of our inspection so we were unable to assess whether actions were taken to improve services.

Innovation, improvement and sustainability

- There was an on-going project in radiology to improve the compatibility of two computer systems, which would improve access to information.

Outstanding practice and areas for improvement

Outstanding practice

The development and management of the Cath Labs was of a very high standard. Staff demonstrated a strong patient centred approach with the policies, procedures and robust monitoring and checks in place to provide a safe service for patients.

We also found strong multidisciplinary working and a proactive approach to ensuring good access and flow for patients that supported consultants and other staff needs. The service had built links with local NHS hospitals and provided facilities that assisted in their management of capacity or if their service suffered interruption. This ensured that patients that otherwise may have had to be cancelled received their treatment and procedures. This had in turn led to a strong support network between KIMS and the NHS hospitals with opportunities for shared practice and improvements.

The radiology department was providing an excellent service using the most modern equipment available.

Facilities management was very good and ensured the environment was well maintained.

Areas for improvement

Action the hospital MUST take to improve

Critical Care:
The hospital must ensure that robust processes are in place for incidents to be investigated and clinical effectiveness to be audited. The processes must include all critical care staff and processes be put in place to ensure that all staff are routinely briefed on the learning and outcomes.

Senior managers must ensure that the opportunities provided for critical care nurses to maintain their skills by working in the CCUs of other hospitals is structured to ensure learning contributes to the sustainability of the department in KIMS.

Outstanding practice and areas for improvement

Medical Care:
The hospital must ensure that the national early warning scores are used in the endoscopy unit.

The hospital must ensure that the resuscitation trolley and appropriate medicines are easily accessible to the endoscopy unit.

The hospital must ensure that medicine storage, including checking process, is in line with best practice in the endoscopy unit.

The hospital must ensure that all substances that come under Control of Substances Hazardous to Health (COSHH) regulations are properly stored.

Outpatients:
The hospital must ensure there is safe and proper management of medicines in outpatients.

Action the hospital SHOULD take to improve

Outstanding practice and areas for improvement

Critical Care:
The hospital should work with existing nurses to ensure that the non-contractual escalation system is fit for purpose and enables them to achieve a work - life balance as well as be able to provide appropriate care and treatment to patients.

Medical Care:
The hospital should ensure that endoscopy patients are cared for and treated in a proper environment.

The hospital should work with staff to improve record keeping.

The hospital should review polices to ensure they are all up to date.

Outstanding practice and areas for improvement

Outpatients:
The hospital should work with staff to develop consistent reporting of incidents in outpatients.

This should include discussion of incidents at staff meetings and demonstrating learning from incidents.

The hospital should ensure staff have knowledge of and are following best practise guidelines in the treatment of patients.

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 KIMS must review and continuously audit its governance policy's procedures and processes to ensure that they are fit for purpose. KIMS must strengthen its incident investigation processes and put systems in place to ensure robust learning from such events. KIMS must provide RCA training for staff expected to carry out RCA investigations. Develop a scope of practice document that includes details of all permitted procedures. This should include exclusion criteria so that staff and consultants are made aware of the limitations on their practice.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider must put in place arrangements for end of life care patients to be referred to palliative care specialists and to be included in local palliative care multidisciplinary team networks. The provider must finalise the policy for end of life care, the end of life patient needs assessment and care planning tool, and end of life medication guidance and must make these available to staff.

This section is primarily information for the provider

Requirement notices

The hospital must not offer diagnosis, treatment or surgery to women with suspected breast cancer until such time they can provide a comprehensive one-stop diagnostic clinic and support services in accordance with NICE guidance.

The provider must review the arrangements for endoscopy. There must be ready access to reversal agents for patients recovering from sedation.

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 hospital must review their website to ensure its not advertising surgical procedures and a level of intensive care that cannot currently be provided at the hospital.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must ensure that the staffing on the critical care unit meets the national guidance on staffing levels and use of agency staff issued by the Intensive Care Society.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The hospital must ensure flooring in clinical areas complies with the requirements of Health Building Note 00-09: Infection control in the built environment. Carpets must be removed from areas where patients are cared for or treated.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered provider must ensure staff completing Do Not Attempt Cardiopulmonary Resuscitation forms are competent to do so and that the forms are completed fully and correctly.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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