

The Lister Hospital

Quality Report

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

Ratings

Overall rating for this location

Outstanding 

Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Outstanding 
Are services well-led?	Outstanding 

Summary of findings

Letter from the Chief Inspector of Hospitals

The Lister Hospital is operated by HCA International Ltd. The hospital employs over 500 consultants and nursing staff and has 61 beds. Facilities include four operating theatres, a six bedded level 3 critical care unit and an endoscopy suite.

The hospital provides surgery, medical care, critical care, and outpatients and diagnostic imaging. All services at this hospital were inspected during our visit.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 28 February – 2 March 2017.

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

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

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

Services we rate

We rated this hospital as **'outstanding'** overall because:

- Patients were treated with compassion and their privacy and dignity were maintained. Patient feedback forms were positive, as were comments we received from patients themselves.
- The needs of individuals were taken into account when planning care and treatment. Patients could access care when they needed it. There was a choice and flexibility around appointments and most procedures were elective.
- The hospital was managed by a team who had the confidence of both patients and their teams. Staff felt motivated and supported by the management team. The vision and strategy of the service was embedded and staff spoke very highly of their management team.
- There were adequate systems to keep people safe and learn from incidents. Learning from incidents that occurred in other departments was shared across the service.
- The environment at the hospital was visibly clean and well maintained. There were appropriate measures in place to ensure the spread of infection was prevented.
- There were systems in place to ensure safe storage, use and administration of medicines.
- There were sufficient nursing and medical staff to ensure patient safety was maintained at all times.
- Care was planned and delivered in line with current evidence-based guidance, standards and best practice. Patient outcomes were collected and monitored to improve care.
- We observed evidence of collaborative working and positive relationships across all departments within the hospital.
- There were effective governance structures in place.

We found areas of 'outstanding' practice in surgery services and critical care services:

Summary of findings

- Within surgery, we found that staff went above and beyond their duty to accommodate patients' individual needs in different ways.
- We found a culture of friendly professionalism, support and respect at all levels throughout the surgical division.
- In critical care, staff demonstrated a consistent approach to providing highly individualised care that contributed to emotional wellbeing and a positive recovery. This included facilitating family visits at mealtimes, and learning Arabic to communicate effectively with patients and their families. Individual examples included ordering fresh flowers to decorate a patient's hair ready for discharge, and inviting a relative to eat lunch with staff each week.
- A consultant intensivist led a critical care post-discharge support programme (PDSP), that was based on a holistic model of care. This meant the service provided support for improved physical health and wellbeing, as well as for psychological health. The PDSP had an international scope. Patients who were discharged to countries outside of the UK had access to this by video link.

However, we also found the following issues that the service needs to improve:

- The hospital should ensure that the quality of documentation of consultants is monitored and any issues are addressed.
- Not all staff had access to the same system for documentation.
- Not all staff had completed their mandatory training, and in many cases the hospital target of 85% was not met.
- Not all complaints in the medical service were responded to within the 20 day timeframe.
- We found high vacancy rates for inpatient and theatre staff and high turnover rates of inpatient nurses.
- In radiology, we found that that prescription pads were not stored securely and there was no system in place to log usage of prescription pads.
- The safeguarding children's policy was out of date as it had not been reviewed in June 2016.
- The outpatients department did not have a separate waiting area for children.

Following this inspection, we told the provider that they should make some improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good ●	<p>Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.</p> <p>We rated this service as good because it was safe, effective, caring, responsive and well-led.</p>
Surgery	Outstanding ☆	<p>Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.</p> <p>The operating area had four theatres and patients were admitted to the day surgery unit and a mixed surgical and medical ward.</p> <p>There had been 9526 inpatient and day case attendances between October 2015 and September 2016.</p> <p>The service mainly offered in-vitro-fertilisation and gynaecological procedures, followed by orthopaedic surgeries.</p> <p>Staffing was managed jointly with medical care.</p> <p>We rated this service as outstanding because it was safe, effective, caring, responsive and well-led.</p>
Critical care	Outstanding ☆	<p>Critical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.</p> <p>The hospital has four level three intensive care beds in private rooms and two level two high dependency beds in a bay. Critical care services are provided in a dedicated unit with direct access from theatres and a critical care outreach service is provided 24-hours, seven days a week.</p> <p>We rated this service as outstanding because it was safe, effective, caring, responsive and well-led.</p>
Outpatients and diagnostic imaging	Good ●	<p>Outpatients and diagnostic imaging services were present at the hospital. There were a total of 47,836 outpatient attendances between October 2015 and September 2016.</p> <p>We rated this service as good because it was safe, effective, caring, responsive and well-led.</p>

Summary of findings

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Outstanding



The Lister Hospital

Services we looked at

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

Summary of this inspection

Background to The Lister Hospital

The Lister Hospital is owned and operated by HCA International Ltd. The hospital opened in 1985 and has been part of HCA healthcare since 2000. It is a private hospital in Chelsea, London with easy access to public transport and underground links. The hospital has 61 inpatient beds, four theatres, six critical care beds and a day surgery unit. Services are provided from Chelsea Bridge Road.

The hospital provides service to both UK and international patients with medical insurance, those who are sponsored by their respective embassies, those who self-fund and a very limited number of patients referred through NHS contracts.

The hospital had a registered manager in post since 2012. At the time of the inspection, Suzanne Canham had been appointed and was registered with the CQC in February 2017. The provider's nominated individual for this service was Michael Neeb. The Controlled Drug Accountable Officer was Sarah Frost (Chief Nursing Officer).

The hospital also offers cosmetic procedures, such as dermal fillers and laser hair removal, ophthalmic treatments and cosmetic dentistry. We did not inspect these services as they are not within our remit under our current methodology.

Our inspection team

Our inspection team was led by Michelle Gibney, Inspection manager, Care Quality Commission. The team included five CQC inspectors and a variety of specialist advisors, including directors of nursing, consultants, nurses and pharmacists.

The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Information about The Lister Hospital

The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning
- Surgical procedures
- Treatment of disease, disorder or injury
- Management of supply of blood and blood derived products

We inspected four core services at the hospital. These were: medicine, surgery, outpatients and diagnostic imaging and critical care. Despite the hospital having a sizeable IVF clinic, we did not inspect fertility services. This is because providers of fertility services in the UK are

regulated by the Human Fertilisation and Embryology Authority (HFEA) and licensed under the Human Fertilisation and Embryology Act 1990 (as amended) (the HFEA Act).

During our inspection we visited the imaging department, the endoscopy suite, four theatres, a variety of consulting rooms, the six-bedded critical care unit, the day surgery department, the 20-bedded orthopaedic ward, the 14-bedded general surgery ward and outpatient therapies department.

We reviewed a wide range of documents as well as data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys and audits. We placed comment boxes at the hospital

Summary of this inspection

before our inspection, which enabled staff and patients to provide us with their views. We also received 30 'tell us about your care' comment cards which patients had completed prior to our inspection.

We carried out an announced inspection between 28 February and 2 March 2017.

We held focus group meetings where staff could talk to inspectors and share their experiences of working at the hospital. We interviewed the management team and chair of the Medical Advisory Committee. We spoke with over 50 staff including: registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 18 patients and two relatives. During our inspection, we reviewed 16 sets of patient records.

There were no special reviews or investigations of the hospital on-going by the CQC at any time during the 12 months before this inspection. The hospital has been previously inspected five times, with the most recent inspection in March 2015. This found that the hospital was meeting all standards of quality and safety it was inspected against.

In the reporting period October 2015 to September 2016, there were 9,526 inpatient episodes of care. Of these, less than 1% were NHS-funded and 99% were funded by other means. In the same reporting period, there were 47,836 day case episodes of care recorded. Of these only 0.1% were NHS-funded and 99.9% funded by other means.

Between October 2015 and September 2016, the most common surgical procedures performed were classified as IVF (2400), gynaecology (908) and orthopaedics (1052). There were 8,791 visits to theatre in this time frame. In the same reporting period, the most common medical procedures performed were spinal injections (779), oesophago-gastro-duodenoscopy (694) and colonoscopy (476).

There were 481 doctors with practising privileges at the hospital. Between October 2015 and September 2016, 9% (41) doctors had over 100 episodes of care at the hospital. In total, 40% (190) doctors had between one and 99 episodes of care at the hospital, and a further 52% (250) did not carry out any procedures at the hospital.

There were 107 registered nurses employed at the hospital. Use of bank and agency nurses staff varied from

between 21% (August 2016) to 44% (April 2016). This is higher than the average of other independent acute hospitals we hold this type of data for in the reporting period. There were no health care assistants (HCAs) directly employed by the hospital in the reporting period. Instead, HCAs were employed via the bank or agency.

Staff sickness rates for inpatient nurses varied from 0.8% (May 2016) to 8.4% (August 2016). Sickness rates for outpatient nurses ranged from 1.3% (January/February 2016) to 3.7% (May 2016). This is higher than the average of other independent acute hospitals we hold this type of data for in the reporting period. Within theatres, nurse sickness rates varied from 0% (July/August 2016) to 4.9% (March 2016). This is lower than the average of other independent acute hospitals we hold this type of data for in the reporting period.

There were no unfilled shifts across the hospital between October 2015 and September 2016. This is lower than the average of other independent acute hospitals we hold this type of data for in the reporting period. In this same reporting period, staff turnover for inpatient nurses was 25%. For outpatient nurses, turnover was 20%, and for theatres it was 14.7%. This is lower than the average of other independent acute hospitals we hold this type of data for in the reporting period.

Between October 2015 and September 2016, the CQC received three direct complaints about the hospital. The hospital received 99 formal complaints in the same reporting period. Two of these complaints were referred to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).

In the reporting period of October 2015 to September 2016, there were no serious incidents and no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. There were 508 clinical incidents during this time period. Of these incidents, 65% (331) occurred in surgery or inpatients and 11% (58) occurred in other services. The remaining 23% (119) occurred in outpatient and diagnostic imaging services. The assessed rate of clinical incidents in surgery, inpatients or other services (per 100 bed days) is lower than the rate of other independent acute hospitals we

Summary of this inspection

hold this type of data for. The vast majority of these incidents (70%) resulted in no harm, and 26% resulted in low harm. There were no incidents categorised as resulting in severe harm or death. There were no unexpected deaths reported to the CQC between October 2015 and September 2016.

There was one safeguarding concern reported to the CQC in the reporting period (October 2015 to September 2016).

Between October 2015 and September 2016, there were no cases of MRSA or MSSA and no incidences of E-Coli. There was one incidence of Clostridium difficile (C. diff) infection, which occurred between July 2016 and September 2016.

Services accredited by a national body:

- Central decontamination unit had an ISO 90001 and EN ISO 13485 certification for central decontamination unit
- CHKS accreditation for risk and safety and leadership & corporate management modules
- The fertility clinic is licensed by the Human Fertilisation and Embryology Authority (HFEA) licensed.
- The fertility clinic has a ISO 9001:2008 certification.
- Theatres had an Association for Perioperative Practice (AfPP) accreditation.

Services provided at the hospital under service level agreement:

- Agency nursing
- Air handling unit servicing
- Clinical waste management
- Health and safety and estates assurance
- Imaging equipment maintenance
- Integrated theatre systems
- Manned security key holding
- Medical device maintenance and calibration
- Medical gases
- Microbiology support
- Night-time contract cleaning
- Nitrous testing
- Pathology
- Radiation protection
- Security assess control and CCTV
- Spiritual care
- Vascular imaging

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as good because:

- There were systems in place to report safety incidents and near misses. Learning from incidents that occurred in other departments was shared across the service.
- Medicines were managed and stored appropriately. Staff told us the pharmacy services were easily available and pharmacists visited the wards daily.
- Sufficient infection prevention control (IPC) measures were taken throughout the wards and endoscopy department.
- Nursing staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk, or had been exposed to abuse. They knew how to escalate concerns and were up-to-date with appropriate levels of safeguarding training.
- Patients were assessed for a variety of risks on admission to the wards, using nationally recognised tools. Processes were in place to identify and control patient risks. A critical care outreach team was available to provide support and advice when a patient's condition deteriorated.
- There were sufficient nursing and medical staff to ensure patient safety was maintained at all times.
- Staff had awareness of what actions they would take in the event of a major incident, including a fire.
- In the critical care unit, nurse and medical staffing consistently met the requirements of the Faculty of Intensive Care Medicine (FICM) and Intensive Care Society (ICS) Core Standards for Intensive Care Units. This included in relation to nurse to patient ratios, consultant review time and the availability of intensivists out of hours. A dedicated team of registered medical officers (RMOs) provided medical support 24-hours a day, seven days a week.

However,

- There were no dedicated hand washing sinks in patient rooms. This meant there was a risk of cross infection from ineffective hand hygiene.
- We noted high vacancy rates for inpatient nursing and theatre staff and high turnover rate for inpatient nurses.
- We identified issues with the legibility of some paper based medical records, where poorly photocopied forms were often used. In one case, a paediatric food chart was used for an adult

Good



Summary of this inspection

patient. Some entries by medical staff were not signed and were illegible. We also found that not all inpatient notes contained full records of consultant-led ward round or review within 12 hours of patient admission. The issue of consultants not reviewing patients regularly and documenting this had been highlighted on the hospital risk register.

- In radiology, prescription pads were only stored securely at night and there was no system in place to record or log the usage of prescription pads. This did not meet best practice guidelines for the use of controlled drug stationery.
- Not all staff had completed their mandatory training, and in many cases the hospital target of 85% was not met.

Are services effective?

We rated effective as good because:

- Hospital policies were current and referenced according to national guidelines and recommendations.
- Nursing and medical staff completed a variety of local audits to monitor compliance and improvement.
- Pain was assessed and well managed on the wards, with appropriate actions taken in response to pain triggers.
- The majority of staff received annual appraisals on their performance, which identified further training needs and set achievable goals. Staff were satisfied with the quality of the appraisal process. The hospital was supporting nurses with the revalidation process.
- There was evidence of effective multidisciplinary working within wards and across departments.
- Nursing and medical staff showed a good knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- A consultant intensivist led a critical care post-discharge support programme that supported patients after they left the unit, in order to maintain good standards of physical and psychological health.
- All CCU nurses had completed the provider's critical care foundation course. A further 76% had a post-registration qualification in intensive care nursing, which was better than the Intensive Care Society (ICS) target guidance of 50%.

However:

- Most agency staff did not have access to the electronic care planning system. The hospital instead provided them with paper documentation to record patient progress and risk assessments. This meant there were gaps in the electronic record and the records were disjointed. This issue was

Good



Summary of this inspection

highlighted on the hospital risk register, which stated that all paper notes should be scanned as soon as possible (aiming for within 48 hours of discharge) onto the electronic system. However, this did not tackle the issue of agency staff not having full access to all relevant information to care for each patient. The hospital planned to give all agency staff access to the electronic system.

Are services caring?

We rated caring as good because:

- Patients were cared for in a caring and compassionate manner by staff throughout their stay. The hospital performed well in their inpatient survey. The diagnostic imaging department used their own satisfaction survey. The results showed a consistently high level of satisfaction with the service.
- Patients' privacy and dignity was maintained throughout their hospital stay.
- Staff ensured that patients and their families were informed about their care and were fully involved in any treatment decisions.
- Patients had access to psychological support and counselling services.
- Patients had access to multi-faith spiritual support.

Good



Are services responsive?

We rated responsive as outstanding because:

- Patients were able to access care and treatment in a timely way. There were clear admission processes and no problems with flow or discharge throughout the hospital.
- Within the hospital menu, there were many options to cater for those with different nutritional requirements.
- The needs of individuals with differing complex needs were well considered and largely met by the service.
- Translation services were readily available.
- Appointments could be coordinated between OPD and diagnostic imaging so that patients could be offered one stop clinics. Evening and Saturday appointments were also available.

However:

- There was no multi-faith room on site.
- Not all complaints in the medical service were dealt with within the hospital mandated time scale.

Outstanding



Summary of this inspection

Are services well-led?

We rated well-led as outstanding because:

- The hospital had developed a vision and strategy and communicated this to staff of all levels, enabling them to feel invested in the development of their respective services and the hospital as a whole.
- The leadership team promoted an open and approachable culture, and staff felt comfortable to approach managers with their concerns. Staff felt supported by managers. They were encouraged in their career development to learn and improve.
- The service actively sought patient feedback and initiated improvements according to results.
- Staff feedback results showed good staff engagement and staff felt proud and committed to doing their very best.
- Governance processes and structures reflected the needs of patients, staff and safety standards. There were clear lines of accountability and a range of specialist committees and working groups provided clinical governance oversight and quality assurance.

Outstanding



Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Outstanding 	Good
Surgery	Good	Good	Good	Outstanding 	Outstanding 	Outstanding 
Critical care	Good	Good	Good	Outstanding 	Outstanding 	Outstanding 
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Outstanding 	Outstanding 	Outstanding 

Medical care

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

Are medical care services safe?

Good 

Incidents

- There were no “never events” reported within the medical service in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- A total of 183 clinical incidents and 34 non-clinical incidents were reported in inpatient areas, including endoscopy, between October 2015 and September 2016. Medication incidents accounted for 33% of the total clinical incidents (71), with a further 19% (41) related to clinical assessment (investigations, images and lab tests). In addition, accidents that may have resulted in personal injury accounted for 8% of reported incidents (18). The assessed rate of clinical and non-clinical incidents was lower than the rate of other independent acute hospitals that the Care Quality Commission (CQC) hold this type of data for (in three out of four quarters of the reporting period).
- The hospital used an electronic incident reporting system. All staff we spoke with were familiar with how to report incidents using the system. Nursing staff told us that they felt comfortable identifying and reporting incidents. Feedback and learning points from incidents were shared with staff across the service via email, newsletters and during twice-daily safety briefings and monthly team meetings. An interactive summary of incidents and emerging themes was also available on the electronic dashboards at the nursing station of the ward. Nursing staff told us that medication incidents were discussed, with reminders to check patient charts thoroughly before administering drugs, for example.
- There were no serious incidents (SIs) reported across the medical service between October 2015 and September 2016. Hospital policy stated that all serious incidents were subject to a full root cause analysis (RCA) investigation, after which, action plans were developed where areas for improvement had been identified. Across the service, 80% of managers had completed training in conducting RCAs. The remaining 20% (two managers) were new in post and were booked for upcoming training sessions.
- Monthly morbidity and mortality meetings were held, where both expected and unexpected deaths were discussed, as well as unplanned readmissions or transfers, and other complex cases. Between October 2015 and September 2016, the hospital reported only one death. Minutes from these meetings demonstrated careful consideration of the factors surrounding each death or complex case, as well as any changes that could be made to protect against similar occurrences in future, if appropriate. The hospital did not provide end of life care services.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. In the 12 months prior to our inspection, there were no examples of incidents or complaints that

Medical care

triggered duty of candour requirements in medical department. Despite this, staff that we spoke to demonstrated a good knowledge of the requirements. We saw posters displaying the key principles of the duty of candour regulations in the clinical areas that we visited.

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

- The hospital was not required to use the NHS Safety Thermometer, as they are an independent healthcare provider. This is a tool, which measures harm to patients which may be associated with their care. However, the hospital monitored incidents of patient falls, pressure ulcers, catheter acquired urinary tract infections and venous thromboembolism (VTE). There were dashboards and separate displays in clinical areas that displayed data relating to performance in these key safety areas. This was visible for patients and visitors. These boards indicated how many days had passed since the last incident of each of these types.
- Nursing staff assessed patients for risk of pressure ulcers, VTE and falls on admission to the ward. VTE assessments were not routinely completed in the endoscopy department as the patients were admitted largely as day cases.
- Between October 2015 and September 2016, between 90% to 98% of inpatients were risk assessed for VTE on admission, dependent on quarter. In the same period, there were no reported cases of VTE or pulmonary embolism (PE).
- Between October 2015 and September 2016, there were two incidents of catheter-related urinary tract infections (UTIs) during the course of a hospital admission. The hospital conducted an audit into high impact interventions in November 2016, which included urinary catheter insertion and daily care. The wards on level four and level five scored 100% in most measures, with just one score of 97% for level five in the first quarter of 2016.
- Between October 2015 and September 2016, there were eight reported falls and no pressure ulcers of grade 3 or above acquired after admission to hospital in inpatient wards. In the same period, 95% of patients were

assessed for falls on admission and 90% were assessed for pressure ulcers. Staff were aware of the falls protocol and assessment process, which we saw copies of in the patient notes we looked at.

Cleanliness, infection control and hygiene

- The hospital had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this. Data provided showed that 99% of staff employed by the hospital had completed this training at the time of inspection.
- The Chief Nursing Officer (CNO) was the Director of Infection Prevention and Control (IPC) for the hospital, who staff were aware of and knew how to contact if necessary. Each ward also had an IPC link nurse. Link nurses act as a link between the ward and the infection control team. Their role is to increase awareness of infection control issues and motivate staff to improve practice.
- The IPC committee met every quarter and discussed any outbreaks of communicable diseases, compliance with policy, processes, and relevant IPC audit results. Monthly operating reports included data relating to IPC, which senior staff collated into an annual IPC report. This identified any potential areas for improvement or development in terms of IPC.
- The ward, endoscopy department and communal areas we visited were visibly clean and tidy. Corridors and main entrances were clean and uncluttered. Personal protective equipment (PPE) was available for staff to use. Clinical areas had antibacterial gel dispensers throughout the corridors and in patient rooms. Green 'I am clean' stickers were in use throughout the wards to inform colleagues at a glance that equipment or furniture was clean and ready for use.
- Staff on the wards we visited wore appropriate PPE, such as gloves and aprons, and utilised effective hand-washing techniques. All staff adhered to the bare below elbow (BBE) dress code. In 2016, quarterly hand hygiene audit results varied between 97% and 100% for level four, compared to between 90% and 100% for level five. Audit results in the endoscopy department showed 100% compliance in all quarters of 2016. Action plans included the cleaning of soap and hand towel dispensers and an increase in the number of hand moisturiser dispensers.

Medical care

- There were no dedicated handwashing sinks in patient rooms, although staff could use the patient sinks. This meant there was a risk of cross infection from ineffective hand hygiene and was contrary to guidance in building note 04-01 (adult in-patient facilities), published by the Department of Health. The hospital had recognised this and added the concern to the hospital risk register in October 2014. Mitigations included alcohol sanitizer in every patient room, annual IPC training for staff emphasising importance of hand washing and dedicated hand washing basins in all treatment rooms and dirty utility rooms to enable staff to perform hand hygiene.
- All of the inpatient rooms were single occupancy on the wards we visited and therefore additional isolation areas were not required. There was appropriate signage on these doors. Staff of all levels knew of measures they should take to reduce the risk of healthcare-associated infections.
- Between October 2015 and September 2016, the hospital did not report any cases of hospital-acquired MRSA. MRSA is a bacterium that can be present on the skin and can cause serious infection. In the same period, there were also no cases of E. Coli or Meticillin Sensitive Staphylococcus Aureus (MSSA). MSSA is a type of bacterium that can live on the skin and develop into an infection or even blood poisoning. There was one reported case of Clostridium difficile (C. diff) infection. C. diff is a bacterium that can infect the bowel and cause diarrhoea, most commonly affecting people who recently treated with antibiotics.
- We observed safe systems for managing waste and clinical specimens during the course of inspection. Waste was separated in different coloured bags to signify different categories of waste. The areas where disposed waste was kept were locked in line with hospital policy. Staff used sharps appropriately, dating and signing containers when full to ensure timely disposal. Bins were not overfilled and were temporarily closed when not in use. The hospital conducted a quarterly audit of clinical waste and sharps disposal. In each quarter of 2016, cardiology and endoscopy scored 100% compliance with agreed disposal methods.
- Patients were cared for in single rooms with ensuite facilities.
- In 2016, an annual audit of environment and equipment showed a high level of environment and equipment compliance on level four and level five, as well as the endoscopy department. Throughout our visit, we found the ward and endoscopy unit to be clean, well-lit and bright with appropriate equipment. All portable equipment we checked had been recently serviced and labelled to indicate the next review date. Disposable equipment was easily available, in date and appropriately stored.
- All clinical areas had access to necessary emergency medicines and equipment including defibrillators, resuscitation equipment, anaphylaxis kits and oxygen cylinders. Staff checked these on a daily basis and ensured they were closed with tamper evident seals.
- The endoscopy suite had one procedure room and three cubicles. These cubicles were spacious, with ample room for a bed. They were for patients to both change before a procedure, and fully recover afterwards. These were separated by partitions and curtains could be drawn across. There was access to a bathroom.
- Arrangements were in place for the safe handling of endoscopes and the segregation, decontamination, and storage of endoscopes. We reviewed the flow of instruments through from use to cleaning, decontamination, storage and saw there was good separation of clean and dirty instruments. There was a schedule for the servicing and maintenance of the endoscope decontamination equipment and records of the servicing carried out by an external company. Quarterly water testing also took place, which we saw evidence of.
- On the ward, patients used an electronic call bell system. This allowed staff to monitor how long patients waited for a response, and how long each nursing intervention took. It also helped to identify where staff members may be at a given time. An audit conducted in July 2016 showed that 85% of patients on level five waited under two minutes for a response. A further 13% of patients waited between two and five minutes, with 1.8% waiting up to ten minutes. The hospital planned to carry out observational studies to understand why staff

Environment and equipment

Medical care

found it challenging to answer call bells promptly during busier periods. Recommendations also suggested an acuity and dependency tool, but this was not in place at the time of our inspection.

Medicines

- Each ward area received a daily visit from a clinical pharmacist as well as a pharmacy technician. Nursing staff told us the pharmacy services were available when needed for practical assistance or advice. The lead pharmacist chaired the pharmacy managers group, which included pharmacists from other hospitals within the HCA group. This meeting was used to discuss incidents, trends, safety alerts, implementation of NICE guidance, and to share learning across sites.
- Medicines were stored safely and available for patients when they needed them. All drugs that we checked were within date, with stickers used to indicate those nearing expiry. Care was taken regarding the storage of medicines with similar sounding names (the hospital used 'sound-a-like, look-a-like' stickers). A storage and security audit was conducted in November 2016, in which a senior pharmacy technician reviewed all treatment rooms across the hospital. A total of 13 standards were audited for compliance, with a target of 100%. Level four was found to be partially compliant, scoring 92% overall. Nursing staff were reminded to close medication cabinets when not in use.
- Controlled drugs (CDs) were stored in a locked cupboard, which the nurse in charge held keys for and were checked twice a day. The nurse in charge, along with a qualified nurse, checked drug stock daily and a spot check of the register confirmed levels were correct. An audit of CDs conducted in the third quarter of 2016 showed 88% overall compliance with recorded measures on level five, and 83% overall compliance in the endoscopy unit. Authorised staff signatory lists were not updated and not all entries were completed correctly. On level five, not all errors were signed and dated. Individual audit results and action plans were fed back to the concerned departments, who shared this locally. Whilst on inspection, we found that all CDs were managed and stored correctly, in line with policy and legislation.
- Medicines were stored in a secure, temperature-controlled room, which staff checked and documented for recommended temperature levels daily. Medicines fridge temperature readings were also recorded, giving assurance that medicines requiring refrigeration were stored at the correct temperatures to remain effective (2-8°C). We saw evidence that staff took appropriate action when the temperature readings were out of range.
- The pharmacy team aimed to carry out medicine reconciliation within 24 hours of admission across the wards. Medicine reconciliation is the process whereby the patients current medications are reviewed to ensure the most up-to-date prescriptions are used. In an audit of 10 records across level four and level five, conducted in October 2016, there was 100% compliance with all recorded measures.
- We looked at the prescription and medication records for nine patients. All charts documented allergy status of patients. Records were clear and fully complete in most cases. They showed people were usually given their medicines when they needed them and any reasons for not giving people their medicines were recorded. Staff used prescription charts with pre-printed doses of common medications in the endoscopy department to reduce prescription errors.
- Staff filled out incident reports in cases of medication administration errors. Data provided by the hospital showed that 135 medication incidents had occurred year to date, as of 24 November 2016. Of these, 59 incidents concerned the administration or supply of a medication in a clinical area, and 17 incidents related to a prescription error. A further 13 incidents concerned a patient's reaction to medication and another 13 related to preparation or dispensing of medicines in the pharmacy. All incidents were classified as causing 'low' (33) or no harm (102). Nearly half of the 'low' harm incidents were due to patient reactions to medication (14). A further two incidents were due to fridge failure and had no impact on patient care (just entailing financial loss). Pharmacy bulletins contained learning from incidents.
- An audit of pharmacist interventions took place between July and September 2016. All interventions (142) from the 10 June until the 19 September 2016 were included. The audit found that 100% of interventions were prescribing interventions. Of these, 24 were drugs missed from the prescription and 17 were

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prescriptions with incorrect doses (including paracetamol). Nine interventions concerned CDs. The majority of prescribers involved in these incidents were consultant or consultant anaesthetists (61). When contacted by the pharmacist, 97% of prescribers accepted the suggested interventions, and the pharmacist changed prescriptions accordingly. There were no interventions with severe consequences recorded. The audit recommended that results be shared with various committees and further work be done to identify the main prescribers who contributed to prescribing interventions in order to provide training where necessary, or to establish the root cause. The hospital also developed bulletins regarding CD prescription requirements and paracetamol, and distributed these to clinical areas.

- Medicines were usually available to facilitate timely discharge of patients who were going home. An audit conducted between July and September 2016, with data captured in the second week of each month, showed that 76% of the 116 take home medications were processed within 30 minutes. This had improved from 49% in the previous quarter. The audit found that the discharge planning on level five had improved, with a greater number of take home medications documented as prescribed in advance of discharge. The pharmacy planned to liaise with level four to implement a practical discharge pathway.
- The hospital had an adult antimicrobial guideline for the use of antibiotics, which was in line with national guidance. The antimicrobial lead had worked with the pharmacy team to develop a 'micro guide', which enabled clinicians to access these antibiotic guidelines via an application ('app') on their mobile phones. There were antimicrobial ward rounds attended by a consultant, a pharmacist and the infection control nurse.

Records

- Information governance training was mandatory for all staff working at the hospital. Across the hospital, 85% of all staff had completed this training, meeting the hospital target.
- A mix of paper and electronic patient records were in use. Electronic records had secure access through a password system. Paper records were stored in locked

cupboards behind the nursing station, which prevented unauthorised access. Staff used standardised paper endoscopy records to record admission assessments, completion of pre-procedure checks, information about the procedure, and a record of the sterile items used. Post-procedure checks were also recorded, along with discharge information.

- We looked at nine sets of patients' records. We identified issues with the legibility of some paper based medical records, where poorly photocopied forms were often used. In one case, a paediatric food chart was used for an adult patient. Medical staff had not signed some entries and some entries were illegible. We also found that not all inpatient notes contained full records of consultant-led ward round or review within 12 hours of patient admission. The issue of consultants not reviewing patients regularly and documenting this had been highlighted on the hospital risk register. The register recommended regular audits and follow-up with non-compliant consultants. An audit of 75 records (60 surgical patients and 15 medical patients) was conducted in September 2016. Level five scored 95% overall compliance in terms of consultant documentation, with level four scoring 93%. The audit found some minor issues with regular review of patient (88% compliance on level four) and legibility of entries (80% for both level four and five). Surgical patients showed better compliance (99%) with standards than medical patients overall (94%). The hospital was in the assessment phase of upgrading their electronic record system to enable consultants to access, both on-site and remotely, all clinical records in a user-friendly format.
- An audit of 40 nursing records conducted in August 2016, level five scored 89% overall compliance with agreed measures. The audit found some minor issues with deletions to the patient records, which staff scored through in only 10% of cases. Actions taken by the nurse in response to issues were clearly recorded in only 38% of cases. In addition, only 38% of cases documented the patient's response to interventions other than medication, and 32% did not contain details of the patient's response to PRN medication. The audit results were shared with ward staff and displayed on quality dashboards.

Safeguarding

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- The Chief Nursing Officer (CNO) was the safeguarding lead for the hospital, supported by the Deputy CNO. The hospital had recently set up a safeguarding working group, whose first meeting was scheduled for the first quarter of 2017.
- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Adult safeguarding information was displayed on the ward and endoscopy unit. Staff had access to the up-to-date safeguarding policy on the intranet, in which flow charts for the escalation of concerns were available. Between October 2015 and September 2016, the hospital reported one safeguarding concern to the CQC.
- Safeguarding was part of the hospital's mandatory training, with data indicating that 100% of clinical inpatient staff were compliant with safeguarding adults training at level 1, with 96% trained up to level 2. All appropriate senior staff were trained to level 3.

Mandatory training

- Staff received mandatory training on a rolling annual programme which was provided through a mix of classroom based sessions and e-learning. Staff and managers received email alerts when their mandatory training was due to expire. The mandatory training programme for nurses and RMOs consisted of 10 modules: basic life support, health & safety, equal opportunities and diversity, information governance, ethics and code of conduct, fire safety, mental capacity act and deprivation of liberty safeguards, safeguarding children and adults, infection control and manual handling. Mandatory training completion rates for staff varied between 83% for equality and diversity and 87% for ethics, against a hospital target of 85%. We saw minutes from meetings, demonstrating that senior staff offered time away from direct clinical care to junior staff in order for them to complete any outstanding modules.
- Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death, especially if not recognised early and treated promptly. There was a sepsis protocol

in place at the time of the inspection. The clinical practice facilitator was undertaking local training for nursing staff. At the time of inspection, 85% of relevant nursing staff had undergone this training.

- There were arrangements in place for supporting and managing new nurses, including a comprehensive induction and a supernumerary period, during which senior staff assessed their clinical competencies.

Assessing and responding to patient risk

- We saw the hospital admissions policy, which had clear exclusion and inclusion criteria. The hospital did not admit any patients under 18 years old, women over 20 weeks pregnant, or patients with known severe dementia or significant psychiatric problems. Medical patients with acute neurological issues or myocardial infarction (heart attack) could not be treated at the hospital.
- An electronic system was used for recording and analysing patients' vital signs, to identify when patients were deteriorating. This provided risk scores to trigger the need for further necessary care, based on the national early warning score (NEWS). These scores were included on the daily handover sheet.
- The hospital had an outreach team, made up of staff from critical care, available 24 hours a day, who visited deteriorating patients and observed them closely to allow for timely intervention if required. Staff told us that when they needed to escalate a deteriorating patient, they received a prompt response from the critical care outreach team or relevant resident medical officer (RMO). All RMOs were required to hold an advanced life support qualification. Across the hospital, 79% of all staff had completed basic life support training. In addition, 98% of staff caring for medical patients had completed intermediate or advanced life support training.
- Assessment tools were used for assessing and responding to patient risks, such as the Malnutrition Universal Screening Tool (MUST) and Waterlow pressure ulcer risk assessment tool were all in use. This information was utilised to manage and promote safe patient care. We saw actions taken, such as the use of pressure relieving aids, when patients were identified to be at risk.

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- Staff in the endoscopy unit utilised the World Health Organisation (WHO) safety checklist that involves briefing, sign-in, timeout, sign-out and debriefing. This is used to ensure patient safety throughout the perioperative journey. The National Patient Safety Agency (NPSA) advocates it for all patients in England and Wales undergoing surgical procedures. The endoscopy service audited the use of the WHO checklist by randomly selecting 10% of case records to be reviewed each month. In January 2017, the audit found 70% of records had a completed checklist (falling from 80% in December 2016). A meeting was called in the department, which reminded staff of the importance of completing the checklist. The healthcare assistant (HCA) who scanned the patient record to the electronic system was also asked to check whether the completed checklist was present and flag this if not. In February 2017, the audit found that 100% of records contained a complete WHO checklist.
- The hospital was piloting the use of a 'sepsis 6 trolley' on level four and in the critical care unit. These included all the medicines and documentation forms necessary to start treatment quickly in a patient with suspected sepsis. An audit conducted on level four in the first two weeks of March 2017 showed that all aspects of the sepsis trolley checklist were completed, with expiry dates noted.
- Pathways were in place for the referral and transfer of patients to neighbouring NHS hospitals if this was required. There were two unplanned transfers of patients to other hospitals between October 2015 and September 2016, but neither of these related to medical patients.

Nursing staffing

- Planned staffing levels were appropriate for the acuity and dependency of patients. Senior staff did not use an acuity tool. Staffing levels were reviewed daily against patient numbers, patient acuity and dependency across the wards at the bed management meeting. Where patient dependency required one-to-one care, this could be provided. A supernumerary nurse was in charge on each ward. Between October 2015 and September 2016, no shifts were left unfilled.
- The hospital did not currently employ health care assistants (HCAs), using bank and agency HCAs when

required. This was mainly for one-to-one nursing of patients who required enhanced nursing care, as registered nurses were employed on the wards for routine care of patients. The use of bank and agency nurses in inpatient areas varied between 21% and 44% between October 2015 and September 2016. This was higher than the average of other independent acute hospitals that CQC hold this type of data for. Staff told us that they tried to fill shifts with regular bank and agency staff, who were familiar with the hospital. We witnessed regular staff showing new agency staff around the ward environment. They were given a permanent member of staff to act as a buddy.

- Between October 2015 and September 2016, sickness for inpatient nurses varied between 0.8% and 8.4%. In the same period, inpatient nursing staff turnover was 25.2%, rising from 18.2% (October 2014 to September 2015). Senior staff told us that they were actively recruiting into vacant posts, with several new starters coming into post.
- We attended a nursing handover on level four. It was well structured and comprehensive, with a thorough discussion of each patient. Staff considered involvement of family and the holistic needs of the patient. Referrals and input from other members of the multidisciplinary team were discussed. The ward had developed handover documentation for each member of staff to refer to, which focused on the necessary information needed to provide care for each patient.

Medical staffing

- Consultants worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The medical advisory committee (MAC) was responsible for approving practising privileges for medical staff, overseen by the medical director, relevant directorate manager and clinical director. Consultants with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts.
- All patients were admitted under the care of a named consultant. All admitting consultants were required as part of their practising privileges to visit their inpatients daily, or more frequently as necessary. There was 24

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hour on-call cover available for consultants in general medicine and endoscopy/GI. Consultants made themselves available when required, either on site or on the telephone.

- The wards had arrangements for 24 hour, seven days a week, RMO cover. There were two RMOs on site at all times; one general and one in critical care. General RMOs were never scheduled to work more than 24 hours consecutively. Senior staff told us that site and outreach teams worked with the RMOs on-call at night to support them, whilst also screening calls to promote an opportunity for a rest period.

Emergency awareness and training

- The service had a contingency business plan in place in case of an emergency. Staff had awareness of what actions they would take in the event of a major incident, including a fire. Meetings to discuss simulated emergency situations were conducted yearly.
- Across the hospital, 83% of all staff had completed fire safety training.

Are medical care services effective?

Good 

Evidence-based care and treatment

- Hospital policies were current and appropriately referenced relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines. These were accessible electronically for all staff that had access. All policies sampled were up to date.
- The medical advisory committee (MAC) reviewed patient outcomes and discussed all relevant NICE guidance. There was also a quarterly policy and document group, due to meet for the first time in April 2017.
- The endoscopy unit was not currently Joint Advisory Group (JAG) accredited, although the environment was fit for purpose and allowed patients to undergo procedures in a dignified manner. JAG accreditation signifies formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against agreed measures, covering all areas, including sterilisation and patient satisfaction, for instance. Senior

staff told us that this was due to the environment and size restrictions in the current unit. There were plans to open a new unit and apply for JAG accreditation. The hospital had recruited a lead nurse with experience in this process.

Pain relief

- The hospital used a standardised pain assessment tool, which was recorded on the electronic system. The numeric rating scale (NRS) was used, with patients asked to score their pain from zero to three each time their vital signs were taken. In this scale, zero meant no pain and three was extreme pain.
- Appropriate actions were taken in relation to pain triggers to make patients more comfortable. We saw examples in the records of pain control managed with PRN (pro re nata or administered as required) pain relief. Patient controlled analgesia was available where appropriate.
- The hospital conducted a pain audit in October 2016, which looked at whether pain assessments had been completed, reviewed and appropriate actions had been taken in response. The audit included 20 records from each ward or department. Level four and five both scored 100% in all measures.
- Patients were encouraged to complete a patient satisfaction survey following their visit, which included their views of pain management. A survey of 16 patients on level five in December 2016 found that 100% were satisfied that their pain was controlled. In the endoscopy department, collated 2016 survey results of 160 patients showed that 99% of patients were satisfied that any discomfort they experienced during the procedure was kept to an acceptable level.

Nutrition and hydration

- The hospital screened all patients on admission to ensure they were not at risk of malnutrition. The malnutrition universal screening tool (MUST) was used to identify the risk level of each patient and this was documented in notes we reviewed. We saw that nursing staff completed food and fluid charts where appropriate.
- The hospital was in the process of recruiting a full-time dietitian. However, at the time of inspection, the hospital employed a part-time dietitian, three days a

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week. Support at other times came from a neighbouring hospital. Dietitians reviewed patients on the wards if required and attended multidisciplinary team (MDT) meetings. Discussion of patient's hydration and nutrition was included in handovers.

- An audit conducted in November 2016 looked at the management of nutrition and hydration in 73 patient records. Results were positive, with 94% compliance with agreed measures. Out of the 73 patients, only four patients did not have a MUST score completed within 12 hours of admission.

Patient outcomes

- The service did not participate in any national audits related to medical care, as the numbers of patients who would be eligible to be included was very small. The hospital's annual governance and improvement plan prioritised future participation in national audits, where possible.
- We saw examples of recent local audits that had been completed on the ward and in the endoscopy unit. These included cleanliness and documentation audits, as well as clinical topics such as catheter care. Results of these audits and any learning were shared with staff in team meetings, safety briefings and emails.
- Between October 2015 and September 2016, there were 10 unplanned readmissions of medical patients within 28 days of discharge. Four of these were for abdominal investigations, two were due to chest infections and two were regarding pain management. In addition, one case was attributed to dehydration and the other to a fractured rib.

Competent staff

- Staff told us they had received an appraisal in the last 12 months to assess their continuing professional development (CPD) needs and set realistic and achievable goals. Data showed that 100% of nursing staff caring for medical patients had completed an appraisal in the year prior to our inspection.
- The medical advisory committee (MAC) reviewed each application for practising privileges and advised the hospital chief executive officer (CEO). The advisory function covered granting, renewal, restriction, suspension and withdrawal of practising privileges. Consultant credentials were reviewed via a monthly

report provided to the CEO through the Centralised Credentialing and Registration Service based within the Corporate Office. If there were delays in receiving evidence of up to date documentation, the CEO suspended the privileges accordingly until credentials were provided. There was an annual review of practising privileges, including scope of practice and activity. Any concerns, including competencies, raised about consultants were dealt with through the 'Responding to Concerns' policy via Decision Making Group (DMG) and then the Corporate DMG if required.

- The majority of consultants were appraised through their NHS trust. The remainder with no NHS affiliation were required to report to the Responsible Officer in the hospital. Records showed 100% completion rates of validation of registration for doctors working with practising privileges.
- Nursing revalidation is the new process by which registered nurses are required to demonstrate on a regular basis that they are up-to-date and fit to practice. The CNO was the local hospital lead who supported nursing staff with revalidation. The hospital had run roadshows around what the process involved and how to collate portfolio evidence in 2016, with two further sessions planned for 2017. Nursing staff could book onto additional workshops if they required more support.
- Staff in the endoscopy department had received training on the decontamination, handling and processing of endoscopes, with refresher courses offered annually. External companies that manufactured the equipment provided this training to staff.
- Nursing staff were able to access further training in topics relevant to their area of work. Across the inpatient wards, 94% of staff had received training in the safe use of insulin for patients. Other courses that staff had attended included: care of the deteriorating patient, principles of dementia care, and using clinical audit to improve patient care. Regular team away days also provided the opportunity for staff to review patient care and outcomes.

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- There was no specific training available in caring for patients at the end of life, as the hospital did not provide this service. However, staff were able to describe how they would care for a patient in the last hours of life and provide support to family and friends.

Multidisciplinary working

- The wards held weekly multi-disciplinary team (MDT) meetings for inpatients with an RMO, nurse, pharmacist, dietitian, physiotherapist and other professionals regularly present.
- Relevant professionals were involved in the assessment, planning and delivery of patient care. The care records that we examined confirmed involvement from health professionals such as physiotherapists and dietitians, where necessary.
- Staff told us that the working relationships between professionals within the hospital were generally good and staff worked well together. Doctors and nurses were complimentary about the support they received from one another and the wider team.
- We witnessed staff communicating with social services and other outside agencies in the case of a complex patient who required support following discharge.

Seven-day services

- All patients were admitted under the care of a named consultant who provided consultant level cover in case of absence. Consultants were supported by on-site RMOs 24 hours a day, seven days a week.
- There was access to diagnostic imaging and tests, 24 hours a day, seven days a week. The hospital had access to speech and language therapy (SALT) and dietitians at all times during normal working hours through a neighbouring HCA hospital.
- Pharmacy services were available 8.30am – 7pm on weekdays. The department was also open on Saturday mornings until 12.30pm. An on-call pharmacist was available for advice and support out-of-hours, with access to medicines facilitated by the duty manager.

Access to information

- There were sufficient computers available on the ward and the endoscopy department, which gave staff access to hospital information, protocols and policies.

- Most agency staff did not have access to the electronic care planning system. The hospital instead provided them with paper documentation to record patient progress and risk assessments. This meant there were gaps in the electronic record and the records were disjointed. This issue was highlighted on the hospital risk register, which stated that all paper notes should be scanned as soon as possible (aiming for within 48 hours of discharge) onto the electronic system. However, this did not tackle the issue of agency staff not having full access to all relevant information to care for each patient. The hospital had added this issue to the risk register in February 2017 and planned to give all agency staff access to the electronic system. In the meantime, the use of the national early warning score (NEWS) was recommended when handing over patients and print outs of the electronic documentation were used.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of their duties in relation to obtaining consent. The hospital had an up-to-date consent to treatment policy. There were systems in place to obtain consent from patients before carrying out a procedure or providing treatment, which we saw evidence of in patients' notes.
- Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and Deprivation of Liberty Safeguards (DoLS). All of the staff we spoke with were aware of the key principles surrounding capacity assessments, best interests meetings and who they would contact for support and advice. Across the hospital, 89% of staff had completed training related to the MCA. We saw an example of a best interests assessment, which was detailed and thorough.
- Whilst on inspection, one patient was subject to DoLS. Initially, we found no official extension to the urgent authorisation present in the notes of the patient, who was waiting for a best interests assessor to review them (this should usually occur in seven days). When we asked senior staff about this, they were able to show us the electronic authorisation was complete. They then printed this out and added it to the notes.
- Very few patients died in hospital and so we did not see any do not attempt coronary pulmonary resuscitation

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(DNACPR) forms whilst on inspection. The hospital conducted a DNACPR audit in February 2017, including nine forms in total. All of the DNACPR forms had been signed and dated by the consultant, with discussion with the family and patient documented. All except one form had the reason for DNACPR decision documented on the form.

Are medical care services caring?

Good 

Compassionate care

- Patient consultations, treatment and personal care took place in private rooms that ensured privacy and dignity. Nurses and doctors introduced themselves to patients and sought permission to enter their rooms. There was a corporate privacy and dignity policy. In December 2016, all 16 patients surveyed on level five agreed that staff always treated them with sufficient privacy and dignity.
- Although there were not separate rooms in the endoscopy department, recovery bays were separated by partitions, with curtains to pull across to separate the bays. Staff were able to use the treatment room or turn on background music should they wish to have private discussions with a patient. In the endoscopy department, collated 2016 survey results showed that 99% of 160 patients felt that their dignity was maintained throughout their procedure. Staff worked hard to ensure that patients' privacy and dignity was maintained at all times.
- We observed interactions between nursing staff and patients. Staff checked how patients preferred to be addressed and explained any procedures they were about to undertake, gaining clear verbal consent. Staff were consistently friendly and caring, with a compassionate and sensitive manner. Nursing staff told us that they treated the patients as if they were family members and were able to describe how they would support people from different backgrounds.
- The hospital asked patients to complete a questionnaire on discharge about their experience. The hospital used the Friends and Family Test (FFT) question to assess patients' overall experience. In December 2016, 100% of

the 16 patients surveyed from level five said that they were 'extremely likely' to recommend the hospital and 93% rated the overall quality of care as 'excellent' or 'very good'. The collated results of 160 patient surveys in the endoscopy department across 2016 showed that 99% of patients were 'extremely likely' or 'likely' to recommend the hospital, with 99% rating overall care as 'excellent' or 'very good'.

Understanding and involvement of patients and those close to them

- Discussions with patients and families were evident in all of the notes that we examined. Family involvement was also discussed in handovers, especially when patients were thought to be vulnerable. We observed staff involving patients and those close to them by giving them time to ask questions or clarify comments.
- Written information leaflets were available for patients about a range of treatments and procedures. Results of patient feedback surveys across the hospital had previously shown that patients felt that they did not always receive enough information on their pain medicines prior to discharge. To rectify this, the pharmacy department developed a patient information leaflet that explained the various pain medicines available.
- Of 16 patients surveyed on level five in December 2016, 100% were satisfied with how well informed nursing staff kept them, with 88% feeling that they were always involved as much as they wanted to be in decisions about their care. 94% were fully confident that they knew who to contact after discharge for support or advice.
- In the endoscopy department, 93% of the 160 patients surveyed in 2016 felt that they were as involved as much as they wanted to be in decisions about their care. Of the same 160 patients, 97% felt that that the procedure was explained to them fully, with 99% being given enough information on what to expect after the procedure. After discharge, 98% of patients felt confident that they knew who to contact should they need advice or support.
- The hospital required either a deposit or payment in full before the time of treatment for self-funding patients. Information and support with the payment of fees was available through the admissions department, which

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patients could contact during office hours. The hospital provided written information on how to pay for treatment, as well as including this information on the hospital website.

Emotional support

- Patients had access to spiritual support through the spiritual care co-ordinator. Chaplains were provided through a service-level agreement (SLA) with a neighbouring NHS trust. Chaplains attended the hospital twice a week and visited patients and their families outside of these days on request.
- Patients had access to psychological support and counselling services, provided through a SLA with a neighbouring hospital. Psychological support was discussed routinely in handovers.
- The hospital had access to specialist nurses that could offer additional support and advice. After discharge, the team of specialist nurses made follow-up calls to ensure that patients had no lingering concerns or issues.

Are medical care services responsive?

Good 

Service planning and delivery to meet the needs of local people

- New services were developed in line with the hospital's business plan, incorporating comments from nursing staff and consultants where appropriate. The redevelopment of the hospital included plans to move the endoscopy department and the opening of an oncology ward on level five. We saw proposed floor plans of the new endoscopy suite displayed in staff areas, with space to add comments or suggestions. Staff told us that the hospital was receptive to suggestions and adjustments to proposed plans.
- Family members who were not local to the area were able to stay with the patient overnight if they wished. Visiting hours were not restricted. They were able to access meals and drinks.

Access and flow

- There were 9,526 inpatient and day case episodes of care recorded at the hospital in the reporting period

(October 2015 to September 2016). A smaller number of these were medical patients, due to the relatively small size of the service. Of these, 0.1% were NHS funded and 99.9% were funded privately or by other means. A further 23% of privately funded patients stayed overnight at the hospital during the same reporting period. No NHS patients stayed overnight in this period.

- There were no 'wait times' for treatments or services at the hospital, as such. Staff told us that patients could be admitted at a time that suited them, often on the same day if clinically appropriate. For example, a patient could be admitted to the endoscopy department on the same day, as long as they had been nil by mouth.
- There were daily bed management meetings attended by senior staff to plan patient admissions, transfers and discharges. The day case ward sometimes closed if bed occupancy was low, with nursing staff deployed to the other inpatient wards.
- The endoscopy unit was open from 8am to 6pm Monday to Friday and there was an on call service at night and over the weekend.
- Discharge planning was routinely discussed at handovers, with a multidisciplinary approach taken. The hospital gave patients a discharge letter for their GP. The hospital had introduced a discharge checklist and pack on inpatient wards, which helped staff to ensure that patients were given all the support and information that they needed when leaving hospital. This had been developed in partnership with the pharmacy department as the result of learning from incidents.
- There were no discharges out-of-hours, unless requested by the patient. In 2016, 21 (6.4% of) medical patients were discharged between 10pm and 8am because they requested this.
- The hospital did not audit the number of patients dying in their preferred location and there was no process in place for rapid discharge at the end of life. This was because the hospital did not offer end of life care services. There was a consultant who offered advice and support to palliative patients admitted for other conditions, if necessary.

Meeting people's individual needs

- The hospital sought to make reasonable adjustments to care for patients with complex needs. If special

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requirements were identified prior to admission, the hospital admission policy stated that they would accommodate these. Patients who required room for a wheelchair would be admitted to an appropriate ward or facility with wheelchair access. Hearing loops were available for patients with hearing difficulties. Bariatric furniture and aids were also available.

- An International Patient Liaison Officer provided support to patients from overseas. Staff were aware of how to access an interpreter for patients whose first language was not English. Face-to-face interpreters were preferred, but a telephone interpretation service was also available. Arabic language TV and newspaper services were available. However, most patient information leaflets in areas we visited were not standardly available in languages other than English. Staff told us that these were rarely required.
- The hospital had access to multifaith chaplains. Staff told us that they could always get hold of someone when needed. Chaplaincy leaflets were also available in Arabic. There was currently no multifaith room on site, but the hospital planned to include one in the redevelopment of the main building.
- Staff told us that if a patient wished to be cared for by staff of the same gender they were able to accommodate their wishes.
- Within the catering menu, there were many options to cater for those with different nutritional requirements and provided an extensive choice of food. Menu items catered for those with food allergies and provided halal, kosher and vegetarian options. Catering staff told us that they would substitute or adjust menu items to suit patient preference.
- All staff were required to complete an e-learning package about dementia as part of their mandatory training. In the medical service, 84.6% of staff had completed this training. Additionally, 11 staff across the hospital had attended a full dementia training day to become established dementia champions. They supported staff within their departments when patients with a diagnosis of dementia were admitted to the hospital. The hospital offered patients living with dementia 1:1 nursing care. Family members and carers

were encouraged to be involved in their care as much as possible and 'this is me' booklets were produced to ensure staff were familiar with the best ways to approach caring for each patient.

- The learning difficulties lead for the hospital was the CNO. Nursing staff told us that hospital passports were in use for patients with learning disabilities. They were able to describe reasonable adjustments that could be made for a patient with learning difficulties, such as rearranging the order of procedures to ensure that the patient was seen first or last.

Learning from complaints and concerns

- There was an up-to-date corporate complaints policy available on the intranet. Patient information on how to raise concerns or make a formal complaint was available in each room on the ward. Comment cards were also available, which patients were encouraged to use to share any feedback.
- All formal complaints were recorded promptly on the hospital reporting system, which was monitored via an internal database. The Chief Executive Officer (CEO) took overall responsibility for any complaints. They worked to resolve any complex issues with the CNO. The hospital aimed to acknowledge all formal complaints within 48 hours. A corporate target of 20 working days was set for a full response.
- Between October 2015 and September 2016, there were five complaints attributed to medical care, of which 40% (two complaints) were fully investigated within the 20-day timeframe. Three complaints were from the endoscopy department and involved patients being unhappy with the explanation of the procedure or the payment of fees. The remaining two complaints from level five concerned nursing care and pain relief.
- All complaints were reviewed in the monthly patient experience group and the weekly incident review group (IRG), where actions for improvements were agreed. Learning was shared with the wider teams through departmental team meetings, safety briefings and newsletters. We saw minutes from ward meetings that indicated complaints were discussed. Complaint themes were also reported to the medical advisory committee (MAC) to ensure the hospital's consultant body were included in any learning.

Medical care

Are medical care services well-led?

Outstanding



Leadership and culture of service

- There was a clear senior management structure within the hospital. One matron managed the wards on level four and level five. The hospital had employed a lead nurse for the endoscopy department, who started in post a few weeks prior to our inspection. They reported to the CNO. The Chief Executive Officer (CEO) managed the running of the hospital overall.
- Lines of accountability and responsibility in the unit were coherent and staff were clear of their roles and how to escalate problems. Staff felt well supported by their immediate line managers and felt able to approach them with concerns. The matron who managed the mixed medical and surgical wards was described as proactive and supportive by junior staff. Nursing and medical staff described senior staff as visible and approachable. The CNO and CEO walked the wards regularly to keep abreast of any issues.
- All staff we spoke with were passionate about providing empathetic care. There was a strong team spirit, with all levels of staff, from catering staff to consultants, reporting feeling valued. The medical team worked well together, with consultants being available for RMOs to discuss patients and to give advice. Nursing staff felt that the doctors listened to them and respected them.
- Leaders had access to mindfulness training to support them with managing stress.
- There was an up-to-date whistleblowing policy, which outlined how to escalate any serious concerns. There was a confidential 'here to help' program and telephone service for staff to raise anonymous concerns.

Vision and strategy for this this core service

- The endoscopy service had recently employed a lead nurse who had experience in applying for JAG accreditation. The hospital's business plan incorporated the relocation of the endoscopy department in order to ensure the provision of a waiting area and single sex changing area. The hospital would then begin the process of applying for JAG accreditation. The hospital

had consulted staff on plans for the new unit and staff felt actively involved in the development of the service. We saw evidence that proposals and plans were shared with frontline clinical staff, for comment and suggestions for improvement, prior to them being finalised.

- The ward on level five had recently closed. There were plans to reopen this as an oncology and medical ward in early May 2017. The ward will contain 13 inpatient beds, with half allocated for medical patients and half for the new oncology service.
- The hospital vision was, 'exceptional people, exceptional care'. The strategy to deliver this involved anticipating patient and staff needs through the provision of efficient care pathways and a supportive and open environment. The hospital hoped that high quality care would lead to business growth. All staff we spoke with were familiar with the vision and strategy, which had been developed using staff feedback. We found that the values were clearly embedded in daily practice, with staff providing care to patients that was centred on their comfort and wellbeing.
- The hospital had developed 'Project World Class', which aimed to maintain quality customer service, in addition to professional coaching and team work teaching sessions. All staff were involved in the training to improve patient interaction, which included role-play exercises. The project had been rolled out to other HCA sister hospitals.

Governance, risk management and quality measurement

- There was a defined governance and risk management structure from corporate provider level to hospital and department level. The hospital held a range of clinical governance meetings on both a monthly and quarterly basis. Weekly incident review groups (IRGs) were held to review all incidents, complaints and near misses. A number of working groups had been set up at the end of 2016 where gaps in the governance framework had been identified.
- The medical advisory committee (MAC) oversaw clinical governance issues, key policies and guidance and

Medical care

monitored patient outcomes. It also renewed the practising privileges of all consultants. A gastroenterologist and physician sat on the MAC to represent the medical service.

- Risks were identified and logged on the hospital's electronic risk register, which was monitored with action plans in place. The register recorded the level of risk and the target level of risk. We saw evidence of the risk register being updated on regular basis and discussed at governance meetings. Local departments could add risks to the risk register locally. The governance team would then review these risks prior to approval and acceptance. Managers we spoke with were aware of the risks relevant to their specific areas, such as the lack of single sex changing areas in the endoscopy department.

Public and staff engagement

- The service collected feedback from staff via annual surveys. The most recent survey showed 89% of respondents were clear about their roles and responsibilities. A further 93% felt trusted to do their jobs.
- Staff attended various ward and divisional meetings, as well as additional forums such as CEO forums. These meetings were designed to foster staff engagement, share information and drive forward improvement. Learning was shared via internal newsletters, quality boards and emails.
- Employee of the quarter awarded members of staff for any exceptional performance, in line with the vision of the organisation. Compliments were shared and celebrated with free lunch vouchers given to staff to celebrate good care. The hospital also held an annual summer barbecue and Christmas party for staff.
- Patients were provided with a patient survey on discharge from the wards to gather their feedback. Feedback scores on all aspects of care were averaged and compiled into a monthly report. Monthly and quarterly reports were reviewed by the CNO and CEO, with specific feedback actioned by heads of department accordingly. Senior staff we spoke with were aware of the latest patient feedback and were able to give examples of how change was implemented to improve patient experience. Feedback was also discussed at the

patient experience group. The patient experience working group met quarterly, but unfortunately, patient participation was low. The configuration and need for this group was under review at the time of inspection.

Innovation, improvement and sustainability

- The hospital planned to develop a new oncology inpatient service. The ward on level five had recently closed for refurbishment, due to reopen in early May 2017. Staff recruitment into posts for the service was underway.
- The hospital facilitated GP master classes and speed consulting sessions. GP master classes allowed consultants to present case histories of patients to GPs. Discussion of patient conditions and outcomes were key. Speed consulting involved four stations being set up. Each station would have two consultants who then discussed case histories for learning purposes.
- The hospital was piloting the use of a 'sepsis 6 trolley' on level four and in the critical care unit. These included all the medicines and documentation forms necessary to start treatment quickly in a patient with suspected sepsis.
- The hospital had an adult antimicrobial guideline for the use of antibiotics, which was in line with national guidance. The antimicrobial lead had worked with the pharmacy team to develop a 'micro guide', which enabled clinicians to access these antibiotic guidelines via an application ('app') on their mobile phones. There were antimicrobial ward rounds attended by a consultant, a pharmacist and the infection control nurse.
- Pharmacy staff had researched an electronic medicines administration system already in use in the United States that had the potential to reduce patient risk. As a result, they conducted a 6-month pilot of the barcode medicines administration (BCMA) system. Pharmacy staff spent numerous hours barcoding all the medicines in the hospital. Once complete, nurses scanned the medicines barcodes prior to medicines administration. A computer system captured all the medicines details. The point of the system was to reduce medicines errors related to dispensing and administration. Analysis of the pilot phase showed that this system had the potential to reduce risk, but would work better with an electronic

Medical care

prescribing system. A business case related to this project was being developed. Once implemented, the system would be able to flag medicines allergies and help to reduce the number of medicines errors.

Surgery

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

Are surgery services safe?

Good 

Incidents

- The hospital used an electronic incident reporting system. All staff we spoke with were familiar with how to report incidents on the system. Incident reporting training was included in the staff induction programme, which all staff attended when they commenced employment at the hospital.
- There was a weekly incident review group meeting, attended by heads of departments and governance team. The group discussed all new incidents shared learning from previous incidents, which were cascaded down through emails, newsletters and departmental meetings.
- The hospital reported 199 clinical and 34 non-clinical incidents for medical and surgical services in 2016. Medication incidents accounted for 30.5% of the total clinical incidents (71), with a further 15.9% (37) related to clinical assessment (investigations, images and lab tests). A further 9% (21) of incidents were related to access, appointment, admission, transfer, discharge. Another 8.6% (20) dealt with patient information (records, documents, test results, scans). The assessed rate of clinical and non-clinical incidents was lower than the rate of other independent acute hospitals that the Care Quality Commission (CQC) hold this type of data for.
- Twelve serious incidents occurred in the same reporting period. Serious incidents (SIs) are those that require

investigation. Evidence submitted relating to the occurrence of SIs in the hospital demonstrated that a root cause analysis (RCA) investigation was undertaken where these occurred. Recommendations were made following each investigation.

- A recent serious incident was related to surgical drapes catching fire in theatres. Staff extinguished the fire instantly and the patient was not harmed. The theatre manager immediately began using a less flammable skin disinfectant, ensuring this was effectively communicated to all staff and surgeons. In addition, a new fire risk assessment was added to the World Health Organisation (WHO) safer surgery checklist as consequence. Duty of candour was appropriately applied in this case and the patient received a written apology.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were aware of the requirements, as demonstrated by the above example, and we found that it was embedded into practice in the service.
- There were no never events reported in the 12 months before inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.



Surgery

- Mortality and Morbidity (M&M) meetings were detailed and held monthly. All unplanned readmissions, unplanned returns to theatres, unplanned transfers and cases of mortality were regular topics on the agenda for discussion. We reviewed minutes of M&M meetings and found that they were well attended and sometimes included a presentation for teaching purposes.

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

- The hospital was not required to use the NHS Safety Thermometer, as they are an independent healthcare provider. This is a tool, which measures harm to patients which may be associated with their care. The wards used a web based clinical dashboard available on the hospital intranet, which monitored incidence of venous thromboembolism (VTE), falls and pressure ulcers. A large screen at the nurses' station displayed the dashboard and was visible for patients and visitors.
- Between October 2015 and September 2016, between 90% to 98% of inpatients were risk assessed for VTE on admission, dependent on quarter. In the same period, there were no reported cases of VTE or pulmonary embolism (PE).
- Between October 2015 and September 2016, there were two incidents of catheter-related urinary tract infections (UTIs) during the course of a hospital admission. The hospital conducted an audit into high impact interventions in November 2016, which included urinary catheter insertion and daily care. Level 4 and level 5 scored 100% in most measures, with just one score of 97% for level 5 in the first quarter of 2016.
- Between October 2015 and September 2016, there were eight reported falls and no pressure ulcers of grade 3 or above acquired after admission to hospital in inpatient wards. Staff were aware of the falls protocol and assessment process, which we saw copies of in the patient notes we looked at.
- The wards further had quality boards behind the nurses' desks with monthly updated info sheets displaying patient satisfaction feedback results, audit results or MRSA, E. Coli and Clostridium difficile infection updates.
- The hospital had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this. Data provided showed that 99% of staff employed by the hospital had completed this training at the time of inspection.
- The Chief Nursing Officer (CNO) was the Director of Infection Prevention and Control (IPC) for the hospital, who staff were aware of and knew how to contact if necessary. Each ward also had an IPC link nurse. Link nurses act as a link between the ward and the infection control team. Their role is to increase awareness of infection control issues and motivate staff to improve practice.
- The IPC committee met every quarter and discussed any outbreaks of communicable diseases, compliance with policy, processes, and relevant IPC audit results. Monthly operating reports included data relating to IPC, which senior staff collated into an annual IPC report.
- All areas of the surgical department we visited were visibly clean and tidy. There were no carpeted areas in patient rooms. All equipment we checked was clean and had 'I am clean' stickers to demonstrate they had been sanitised.
- We observed staff complying to good practice in hand washing and bare below elbows practice.
- Throughout the surgical division we saw sufficient hand wash facilities and wall mounted hand sanitizer dispensers in corridors. Attention was drawn to these with hand hygiene notice boards.
- There were no dedicated hand washing sinks in patient rooms. This meant there was a risk of cross infection from ineffective hand hygiene. The hospital had recognised this and added the concern to the hospital risk register in October 2014. Mitigations included alcohol sanitizer in every patient room, annual IPC training for staff emphasizing importance of hand washing and dedicated hand washing basins in all treatment rooms and dirty utility rooms to enable staff to perform hand hygiene.
- In 2016, quarterly hand hygiene audit results showed 100% for level 3, compared to 97% and 100% for level 4. Audit results in theatres showed compliance rates of

Cleanliness, infection control and hygiene



Surgery

93% and 100%. Action plans included the cleaning of soap and hand towel dispensers and an increase in the number of hand moisturiser dispensers. The hospital considered a rate of 90% or above as compliant.

- Staff in all areas had access to personal protective equipment (PPE) such as gloves and aprons. We observed that theatre staff wore the appropriate PPE during surgical procedures.
- We observed theatre staff adhering to theatre dress code and theatre doors had red warning stickers when scrubs were mandatory.
- Disposable curtains in recovery were labelled and dated when they were to be replaced.
- All the patient rooms were single occupancy on the wards we visited and therefore additional isolation areas were not required.
- We observed completed cleaning schedules in all surgical areas.
- Waste management practices were observed and complied with the hospital policy and good practice guidelines for segregation of waste. The areas where disposed waste was kept were locked as per policy. Sharps bins were labelled and dated and bed linen was bagged appropriately. Sluices in wards were clean, tidy and well organised.
- There were no reported cases of MRSA, MSSA (Meticillin sensitive Staphylococcus aureus) or E.coli infections in 2016. Hospital data showed one case of Clostridium difficile infection in the 12 months prior to inspection.
- There were two reported surgical site infections (SSIs) in the 12 months prior to inspection. In one case, a deep surgical infection after disc surgery was identified 21 days post-surgery. In the other, a deep organ space infection was identified seven days post-surgery for a hernia repair. Both incidents resulted in moderate harm and underwent a root cause analysis.
- Decontamination of surgical equipment was done internally. The hospital's central decontamination unit held ISO 9001 and EN ISO 13485 certification for central decontamination units and carried out all of their own decontamination and sterilisation.

- The hospital was registered with the Legionella Control Association and had water tested quarterly. There were no positive results in 2016 and the last test result in March 2017 was negative for Legionella.

Environment and equipment

- All the wards were well organised, clean and well lit. All patient rooms were single bedded with ensuite facilities. All rooms were equipped with oxygen, suction and call bells.
- The operating area had four theatres, all with laminar flow and each with anaesthetic rooms. The theatre areas were well maintained and well equipped. Theatre staff told us they checked in advance to ensure equipment was available and met the needs of the surgical procedures scheduled. Staff told us there were sufficient supplies of equipment and spare equipment was available.
- There were documented daily checks carried out on all equipment prior to use, as well as an annual service programme for all equipment.
- Surgical implants were recorded in the implant and consignment log, electronic patient record and on the patient implant record sheet. Paper records were scanned into the patients' medical records.
- There was a single large blood fridge located in theatres. The temperature was electronically monitored and alerted the duty manager in case the temperature fell out of range. A failing blood fridge was one of the risks on the risk register. In that case, HCA labs would provide temporary blood storage bags. The hospital planned to install a second blood fridge to address that risk.
- The recovery room had five adult bed bays to look after patients immediately after surgery. Each bay was equipped with all necessary devices for monitoring and treatment.
- The resuscitation trolleys in theatre, the recovery area and the wards were recorded as being checked daily and were easily accessible. They were sealed with a tamper evident seal after checks were completed. Any imminent expiry dates were noted and highlighted to pharmacy so that the product could be replaced.



Surgery

- Emergency equipment was available and was checked each day (including oxygen cylinders and anaphylaxis kits).
- Health and safety was part of the mandatory training programme which staff were required to attend. Within the surgical service, 97% of staff had completed the training.

Medicines

- The organisational medicines policies were available on the intranet and staff knew how to access them. They were also able to access stock lists from other hospitals within the provider group, which was useful if a medicine needed to be borrowed from elsewhere out of hours.
- Staff developed a number of medicines optimisation initiatives relating to antimicrobial stewardship. The pharmacy team were instrumental in developing the 'micro guide' in conjunction with the antimicrobial lead. The micro guide enabled clinicians to access the corporate antibiotics guidelines via their mobile phones. In addition, a new drug chart was soon to be implemented which will prompt prescribers to review intravenous antibiotics after two days to see if the patient can be switched to an oral antibiotic. There were also weekly antimicrobial ward rounds attended by a consultant, a pharmacist and the infection control nurse.
- Hospital data showed 100% of patients had their medicines reconciled within 24 hours of admission to the hospital. Medicine reconciliation is the process whereby the patients current medications are reviewed to ensure the most up-to-date prescriptions are used. Timely medicines reconciliation is crucial in reducing risks associated with incorrect medicine information.
- All nurses, including agency and bank nurses received mandatory medicines management training, followed by an exam. They then worked as supernumerary for two weeks before they were confirmed as competent and allowed to administer medicines. Pharmacy staff offered regular teaching sessions to ward staff in various areas, in for example, controlled drug management.
- Medicines (including controlled drugs and fluids) were stored neatly and securely in locked cupboards within a locked clinic room. Access to the room was controlled using a swipe card. Drugs were in date and cupboards were organised.
- The clinical treatment room was clean and had adequate hand washing facilities available, as well as adequate space to prepare medicines.
- Controlled drugs (CD) were stored in appropriate CD cabinets. There were robust systems for the management of CDs in line with legislation. They were checked twice a day by two registered nurses or two members of theatre staff respectively. The storage and administration of CDs was audited quarterly in conjunction with pharmacy staff. Results for the third quarter in 2016 showed overall compliance rates of 96% for level 3, 83% for level 4, 84.5% for theatres and 95% for recovery. Authorised staff signatory lists were not updated and not all entries were completed correctly. On level 4 and in theatres, not all errors were managed correctly. Individual audit results and action plans were fed back to the concerned departments, who shared this locally.
- Flammable preparations were stored in flammable medicines cupboards.
- Fluids in theatre were stored in a cupboard in a high traffic corridor. The fluids were accessed frequently by staff. A decision was taken to leave the fluid cupboard unlocked during the operational hours of the theatre to ensure that staff could access them easily when required. The theatre area was only accessible to relevant staff.
- There were appropriate facilities for the disposal of medicines.
- The minimum, maximum and current fridge temperatures were being recorded for the medicines fridges. All the readings gave assurance that the fridge temperatures had remained within the recommended range for the storage of medicines (2 - 8°C). We saw evidence that staff took appropriate action when the temperature readings were out of range. The minimum, maximum and current ambient room temperatures



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were taken every day and were found to be satisfactory. All the readings gave assurance that medicines were being stored at the appropriate temperatures to remain effective (below 25°C).

- The ward was equipped with a hypoglycaemia box and an extravasation kit. Extravasation is leakage of potentially damaging intravenous medication into surrounding tissues.
- The blood glucose testing kit was calibrated daily and was usually within range. However, on the day of the inspection, the lower range reading was out of range on the day surgery ward. When this was pointed out to the nurse in charge, the machine was immediately re-calibrated, the test solution was replaced and the calibration process was repeated. The readings came back within the normal ranges. No patient blood glucose readings were affected.
- All nine prescription charts we reviewed were clearly written and included information about allergies, height, weight, date of birth, and venous thromboembolism (VTE) risk assessments. There was evidence that medicines reconciliation had been completed on all the prescription charts and the pharmacist had screened each prescription on the chart.
- Day surgery prescription charts were pre-printed with the most common drugs used post-surgery to prevent errors. We saw that prescribers signed to authorise the prescriptions, or crossed them off if the medicine was contraindicated. Allergies, height and weight were clearly recorded. VTE risk assessments were completed for all patients. Whilst medicines reconciliation was not always completed due to the rapid patient turnover, all the discharge prescriptions were screened by a pharmacist.

Records

- The hospital utilised a combination of electronic and paper records. Admission notes, risk assessments, care plans and nursing documentation would be entered and stored electronically. Medical documentation, consent forms, operation and anaesthetic records were kept in the paper record. Upon discharge, all paper documentation would be sent to medical records to be scanned into the electronic patient record.

- Patient records were stored appropriately in locked cupboards and electronic records were not left on screens. Access to the computers and patient confidential information was password protected, with staff having access via personal logins and passwords.
- The anaesthetist documented discussions with patients prior to surgery.
- Consultant's documentation was not always complete. In the patient's records we reviewed on level 3, consultants did not always document their post-operative review of patients on the ward before discharge. Staff we spoke with confirmed this. However, a consultant documentation audit retrospectively looked at surgical notes from September 2016 (level 4 and 5) and November 2016 (level 3). Results showed an overall compliance of 99%. This was above the hospital's target of 90%.
- Agency nurses did not routinely have access to the electronic patient records and documented on paper. At the beginning of the shift, all relevant documents of that nurse's patients would be printed out. However, this meant that electronic patient records were incomplete and disjointed until paper documents were scanned after discharge.

Safeguarding

- Staff we spoke with were aware of how to access the safeguarding policies on the hospital's intranet. All staff we spoke with were aware of their responsibilities to protect vulnerable adults.
- There was information on the hospital's safeguarding procedure displayed on the notice boards on the wards and in theatres for staff to refer to, including the contact details for the safeguarding leads.
- The nominated lead for safeguarding was the chief nursing officer (CNO) and in their absence the deputy chief nursing officer and the outpatient manager. The provider also employed an organisational level safeguarding lead and named doctor.
- Safeguarding adults training was mandatory for all staff. Training records demonstrated 100% of surgical staff had completed safeguarding adults level one and two training as well as children's safeguarding level one and two training.



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- Female genital mutilation (FGM) awareness was covered in safeguarding training. Staff were able to undertake additional FGM specific e-learning through the provider's learning academy.
- The hospital reported one safeguarding concern to care quality commission (CQC) in the reporting period of October 2015 to September 2016.

Mandatory training

- The hospital target for mandatory training was 85%.
- The mandatory training programme for nurses and RMOs consisted of 10 modules: basic life support, health & safety, equal opportunities and diversity, information governance, ethics and code of conduct, fire safety, mental capacity act and deprivation of liberty safeguards, safeguarding children and adults, infection control and manual handling. Mandatory training compliance rates for the surgical division ranged between 85% and 100%.
- Staff were clear that it was their responsibility to keep up-to-date on training. We observed that team leaders and managers had systems in place to ensure that their staff were trained.
- Staff told us the hospital had introduced a 'learning academy' and mandatory e-learning could be completed there.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- The hospital had clear exclusion criteria for surgical services, for example acute neurological, trauma or myocardial infarction patients. Patients under the age of 18 were also excluded from admission.
- Nursing staff recorded and monitored patients' clinical observations in line with NICE guidance. The hospital wards used the national early warning score (NEWS) to identify deteriorating patients. The National Early Warning Score (NEWS) is a scoring system that identifies patients at risk of deterioration, or needing urgent review. Observations were recorded on an electronic system, which automatically calculated the level of risk. When a certain level was reached, the on-call resident

medical officer (RMO) was automatically informed and would review the patient. For high warning scores, the electronic system would automatically send a warning to the RMO on the critical care unit.

- Staff told us that if they had concerns relating to a patient's condition the on-site surgical RMO would be called to assess the patient, as well as inform the patient's consultant.
- Consultants reviewed their patients' condition on a daily basis and ensured pre and post-operative treatment plans were up to date.
- There was a bed management meeting every day during the working week to discuss patient admissions, staffing, bed capacity and patient discharges.
- Patients were assessed for the risk of hospital acquired venous thromboembolism (VTE) at preadmission and on admission prior to surgery. The electronic patient record included mandatory risk assessments such as VTE, falls and skin integrity to be completed.
- The average VTE screening rate in the reporting period (October 2015 to September 2016) was 94.5%. From October to December 2015 the rate of VTE screening was 90%, which improved to 98% and 96% in the two quarters from April to September 2016.
- There had been no reported cases of hospital acquired VTE or pulmonary embolism (PE) following surgery between April 2015 and March 2016.
- The hospital had a pre-operative assessment team which provided advice and information to patients prior to their surgery. This included tests, screening such as MRSA, and offered the patient an opportunity to clarify any details of their surgical journey. The purpose of the pre-operative assessment was to ensure that patients were fully informed about both the procedure and the post-operative recovery, as well as ensuring they were in optimum health and had made arrangements for admission, discharge and post-operative care at home. During inspection, pre-operative assessment was performed by two pre-assessment nurses. They followed a set of standard guidelines, which were used to establish how the patient would be assessed. This was dependent on the patient's clinical and personal



Surgery

circumstances. Assessments could include face-to-face, telephone or online assessment elements. Patients undergoing joint injections, minor excisions or egg collection were excluded from pre-assessment.

- There were processes in place to reduce the risks to patients undergoing surgery. These included the use of the World Health Organisation (WHO) surgical safety checklist, which was embedded in practice. The WHO checklist for surgical safety audit of February 2017 was conducted retrospectively, with a sample size of 10% of patients who were admitted from January 2016 to December 2016. Results showed an average of 99.8% compliance over the year, with 100% compliance in each of the last six months. The audit was continued on a monthly basis. We witnessed two cases in theatres where the WHO surgical safety checklist was completed correctly.
- Theatre recovery staff told us the anaesthetist did not leave the recovery area until the patient was transferred to the ward. An up-to-date telephone list of all anaesthetic consultants was located in the recovery unit, in case they needed to be contacted.
- Basic life support (BLS) was part of the mandatory training programme which all staff were required to attend. Within the surgical service, 95% of staff had attended this training.
- There was a blood fridge located in theatres, which contained cross-matched blood and emergency blood provided by HCA labs.
- The theatre manager told us that theatre staff utilised a provider wide standardised surgical count board to document numbers of accountable items in theatres, for example number of swabs. This helped to reduce errors.
- A sepsis standard operating procedure based on NICE guidance was available for staff. It included the escalation process and guidance on antibiotic treatment. Staff utilised a screening and action tool for patients with suspected sepsis and a sepsis pathway if appropriate.

Nursing and support staffing

- During our inspection, all wards and theatres were safely staffed with enough nurses and healthcare assistants. The staffing in surgery and theatres was flexed according to activity and was reviewed daily by

managers. The day surgery unit was closed on Sundays or bank holidays and did not require staffing on those days. At the time of inspection, the ward on the fifth floor was closed for refurbishment and nurses worked shifts on the fourth floor ward.

- Duty rotas confirmed that the staffing levels in theatre during surgical procedures was compliant with recommendations from the Association for Perioperative Practice (AfPP).
- Planned staffing levels were appropriate for the acuity and dependency of patients. Staffing numbers and skill mix were reviewed daily against patient numbers and patient acuity level. The hospital used a system that allocated staff in advance based on pre-determined nursing demand. For patients requiring 1:1 care, the service relied on the use of bank and agency staff.
- We observed a nurse handover with comprehensive briefings about all the patients on the ward. There was a handover document for staff to refer to. It contained essential information to provide appropriate patient care.
- Hospital data for theatres showed there were 23.7 whole time equivalent (WTE) nurses and five WTE operating department practitioners (ODP) and health care assistants. The vacancy rate as of October 2016 was 23%. This was higher than the vacancy rate for this staff group in other independent acute hospitals we hold this type of data for. The hospital explained that new posts were created in the same period, which accounted for the higher vacancy rate.
- During the reporting period (October 2015 to September 2016), the theatre staff turnover rate was 14.7%. This was lower than the average of other independent hospitals we hold this type of data for.
- In the same period, the theatre nurses sickness rate was 1.3%. This was lower than the average of other independent hospitals we hold this type of data for.
- Hospital data showed 40.3 WTE inpatient nurses. Health care assistants were not permanently employed across the wards. In instances where patients required enhanced levels of care, the hospital would employ bank or agency health care assistants. The vacancy rate, as of October 2016, was 27%. This was higher than the



Surgery

vacancy rate of this staff group in other independent hospitals we hold this type of data for. New posts were created in the same period throughout the department, which accounted for higher vacancy rates.

- During the reporting period October 2015 to September 2016, the nursing turnover rate was 25.2%. This was higher than the average of other independent hospitals we hold this type of data for. The hospital explained this with internal recruitment of staff to senior roles and staff not returning after maternity leave.
- In the same period, the nursing sickness rate was variable, with an average of 4%. This was higher than the average of other independent hospitals we hold this type of data for but in line with national average.
- The rate of use of bank and agency staff in inpatients departments was 36.9% (19.3% agency staff). This was higher than the average of other independent acute hospitals we hold this type of data for in the reporting period (October 2015 to September 2016). The ward managers explained that most bank nurses worked regularly for the Lister Hospital but wished to remain bank staff. They were subject to the same mandatory training programme and had access to the provider-wide e-learning academy.

Medical staffing

- The service was consultant led. Records we viewed confirmed that consultants reviewed all patients on a daily basis.
- Medical staff worked under a practising privileges agreement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital.
- A team of surgeons and anaesthetist consultants provided seven day, 24 hour on-call cover for theatres. In addition, urology, medical and gastroenterology consultant on-call cover was provided. It was a robust on-call system and consultants were paid for being available on-call. We were shown the rotas for 2017, which were managed by the day surgery unit manager.
- All the wards had arrangements for 24 hour, seven day a week resident medical officer (RMO) cover. Five RMOs were employed by the hospital with one vacancy, remaining shifts were covered by bank or agency RMOs,

most of them working regularly for the Lister Hospital. All RMOs were required to have a current advanced life support (ALS) certificate. We were shown evidence of this. There were two RMOs on site at all times; one general and one in critical care. The general RMOs were not scheduled to work more than 24 hours consecutively.

Emergency awareness and training

- Fire Training formed part of the mandatory training programme. Within the surgical division, 96% of staff had received this training.
- There was a hospital-wide major incident policy. The duty manager had overall responsibility to maintain an overview of all the incidents which could have the potential to affect the hospital. In the event of an emergency, the duty manager would manage the emergency control room and be in charge of the response.

Are surgery services effective?

Good



Evidence-based care and treatment

- The service had a comprehensive and varied audit programme. VTE, malnutrition universal screening tool (MUST), falls risk assessment as well as pain, discharge, Waterlow and National Early Warning Scores (NEWS) were all audited 20 times a month. Blood transfusion, acute kidney injury and consent were also included in the audit calendar. Theatres conducted monthly audits of WHO checklist completion and 5 steps to safer surgery. Other audits included: monthly peripheral line insertion audits, urinary catheter insertion and continuing care audits, various environment and equipment audits, as well as audits related to pharmacy services.
- We reviewed a sample of hospital policies and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines. Policies and guidance were easily accessible to staff on the hospital's intranet.
- The hospital complied with the NICE CG50 (2007) guidance on recognition of and response to acute



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illness in adults in surgery services. We observed patients receiving regular observations, for example, blood pressure and oxygen saturation, to monitor their health post-surgery. This was in line with NICE guideline CG50.

- Theatres held a certificate of accreditation by the association for perioperative practice (AfPP). The AfPP had facilitated an audit review of theatre department in 2016 and were satisfied they met AfPP national standards and recommendations for safe perioperative practice.
- The service also took part in the National Joint Registry (NJR) for their orthopaedic surgical cases. The NJR was set up by the Department of Health and Welsh Government in 2002 to collect information on all hip, knee, ankle, elbow and shoulder replacement operations, to monitor the performance of joint replacement implants and the effectiveness of different types of surgery. Between April 2015 and March 2016, the hospital recorded 109 joint procedures (with the national average being 541).
- The hospital had begun submitting Patient Reported Outcome Measures (PROMs) to Quality Health. This captured outcomes on hip replacements, knee replacements, hernias, prostate resection and cataract procedures. The first outcome report was expected in quarter two of 2017.
- There was an implementation plan in place for national and local safety standards for invasive procedures (NatSSIP and LocSSIP). They bring together national and local learning from the analysis of 'never events', SIs and near misses, through a set of recommendations that enable staff in providing safer care for patients undergoing invasive procedures. For theatres, the hospital undertook the five steps to safer surgery for all surgical lists and audited this on a monthly basis.

Pain relief

- Patients' notes showed that pain relief was prescribed by the anaesthetist perioperatively and reviewed by the consultant. The RMOs and nursing staff ensured patients' prescribed pain relief was effective when they reviewed patients.
- The eight sets of medical notes we reviewed showed that patients had been given regular pain relief

post-operatively. Patients confirmed that they were frequently asked by staff what their pain level was, and were not kept waiting for analgesia. The hospital utilised a 0-3 pain score, which was documented on the electronic patient observation system.

- The hospital conducted a pain audit in October 2016, which looked at whether pain assessments had been completed, reviewed and appropriate actions had been taken in response. The audit included 20 records from each ward. Level 3 and 4 both scored 100% in all measures.
- Hospital staff conducted patient feedback surveys. Results showed that patients felt that they did not always receive enough information on their pain medicines prior to discharge. To rectify this, the pharmacy department developed a patient information leaflet that explained the various pain medicines available.
- Theatre staff told us that all patients were reviewed by the anaesthetist prior to leaving the recovery area to ensure they were comfortable and their pain was managed.

Nutrition and hydration

- The wards used the malnutrition universal screening tool (MUST) to assess patients for the risks of dehydration or malnutrition on admission. Hospital data showed a completion compliance rate of 100% for the day surgery unit and wards on level four and five in October 2016 to January 2017. Overall compliance with audit standards was 98% for the day surgery unit and 86% for level four during the same period. An action resulting from the audit was to discuss process of escalation to dietitians for patients with a MUST score of two or more.
- The hospital followed the local pre-procedure fasting policy which was based on the 'perioperative fasting in adults and children' guidelines published by the Royal College of Nursing (2005). Recommended fasting times were six hours for food, and two hours for clear fluids.

Patient outcomes

- Data provided showed there had been 9526 inpatient and day case attendances between October 2015 and September 2016. In the same period there had been 31 unplanned readmissions within 28 days of discharge



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for surgical services. However, this number was not high when compared to a group of acute independent hospitals which submitted data to the CQC. Most common reason for unplanned readmission was postoperative complication.

- Between October 2015 and September 2016, there was one unplanned transfer of an inpatient to another hospital. A patient was transferred to a specialised facility because of a suspected cerebral event, which occurred postoperatively. The number of unplanned transfers was not high when compared to the performance data submitted by other acute independent hospitals.
- There had been 13 cases of unplanned returns to the operating theatre between October 2015 and September 2016. Reasons for these varied, 31% (4) were attributed to postoperative wound complications, 23% (3) to postoperative fluid collections and others to postoperative haemorrhage or further investigations for example.
- Data from the National Joint Registry (NJR), from April 2013 to July 2015, showed the hospital performed within the expected range of the national average in regards to 90-day mortality and revision rates for hip and knee replacements.

Competent Staff

- Hospital data showed 100% of nursing, theatre and medical staff had received an appraisal in the year prior to our inspection.
- All inpatient nursing staff in the surgical division had a folder on the ward with their individual competency checks. They were able to keep their certificates and information relating to upcoming competency opportunities in these. A clinical practice facilitator supported nursing staff in this.
- Theatre staff told us they had access to career and professional development opportunities. This included attending external courses to complete additional qualifications such as a degree or a surgical first assistant course.
- Orthopaedic patients were supported by an orthopaedic nurse specialist who saw patients before and after surgery.

- Pharmacy staff rotated to different hospitals within the HCA group to gain experience in different clinical areas.
- The medical advisory committee (MAC) reviewed each application for practising privileges and advised the hospital chief executive officer (CEO). The advisory function covered granting, renewal, restriction, suspension and withdrawal of practising privileges. Consultant credentials were reviewed via a monthly report provided to the CEO through the Centralised Credentialing and Registration Service based within the Corporate Office. If there were delays in receiving evidence of up to date documentation, the CEO suspended the privileges accordingly until credentials were provided. There was an annual review of practising privileges, including scope of practice and activity. Any concerns, including competencies, raised about consultants were dealt with through the 'Responding to Concerns' policy via Decision Making Group (DMG) and then the Corporate DMG if required.
- Consultants were appraised through their NHS trust. Those without NHS affiliation were reported to the responsible officer in the hospital. Records showed 100% completion rates of validation of registration for doctors working with practising privileges.

Multidisciplinary working

- There was a weekly multidisciplinary team (MDT) meeting on the wards. We observed one of the ward MDT meetings during inspection. It was attended by the matron, ward sister, RMO, physiotherapists and occupational therapists. All patients were discussed, with input from all attendees. We saw good team communication in a relaxed atmosphere, which facilitated detailed discussion about complex patients.
- A breast MDT meeting took place weekly, as well as a skin MDT meeting every six weeks. Senior staff told us that additional MDT meetings would be organised if required.
- Each ward area received a daily visit from a clinical pharmacist, as well as a pharmacy technician. Pharmacy staff spent time talking to patients about their medicines prior to discharge whenever possible. Pharmacists were involved in multidisciplinary team meetings to optimise the use of medicines.

Seven-day services



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- There was a 24 hour, seven day a week on-call presence of RMOs to cover surgical inpatient care.
- There was 24 hour, seven day a week on-call rota for anaesthetist cover. The service also provided 24 hour, seven day a week on-call cover by surgical, urology, medical and gastroenterology consultants. We were shown evidence of this.
- The service provided a daily unplanned theatre service, with an on-call theatre team.
- Radiology services provided a seven days a week, 24 hours a day on-call service out of hours.
- There was an on-call pharmacist service available out of hours, when the hospital pharmacy service was not available. The pharmacy service was operational on weekdays from 8.30am until 7pm. The pharmacy department was also open on Saturday mornings until 12.30pm. A duty manager facilitated access to medicines when the pharmacy department was closed.

Access to information

- Staff they were able to access patient information promptly from the electronic patient record. Staff said there were sufficient supplies of computers available in clinical areas. Portable computers on wheels enabled staff to directly enter patient information at the bedside and other areas of the hospital.
- Agency nurses without access to the electronic patient record system had limited access to patient information. However, relevant documents were printed out for them at the beginning of the shift and they would be able to ask one of the supernumerary staff for assistance.
- Previous medical records, information about previous admissions, blood results and x-ray reports were accessible on the electronic patient record system. X-ray images were accessible through a separate piece of software for diagnostic imaging.
- Discharge information was communicated to GPs via a letter, which every patient received with their discharge packs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was generally obtained on the day of surgery by the patient's consultant surgeon. Patient notes

contained a copy of patients' consent forms. The eight sets of notes we reviewed confirmed that all consent to surgical procedure forms were signed, dated and legible. They included the risks and benefits of the procedure the patient was undergoing.

- There were checks that consent had been obtained on the ward, on arrival in theatre, and before the administration of anaesthesia. This was in accordance with the World Health Organization (WHO) surgical safety checklist and best practice guidance.
- Staff told us they rarely had patients who lacked capacity. Staff told us they had received mandatory training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Data provided showed a compliance rate of 94% for staff working in the surgical division. Staff we spoke with were able to demonstrate that they understood their responsibilities in relation to the MCA and DoLS.

Are surgery services caring?

Good



Compassionate care

- The five patients we spoke with provided unanimous positive feedback about the treatment and care they received from the hospital staff. One patient said she had "everything I need[ed]". Other patients said the staff were very welcoming and kind, and processes worked like a "well-oiled machine".
- We observed staff being kind, respectful and polite when speaking to patients and delivering care.
- All patients received a patient experience questionnaire upon admission and were encouraged to complete them. We observed nursing staff encouraging patients to fill out the forms and offering to post them to the headquarters that collated the results. Patient feedback results showed that 95.8% of inpatients and 97.3% of day case patients were satisfied with quality of care in 2016. A further 91.5% of inpatients and 97.3% of day case patients were satisfied with nursing care. A total of 1498 patients responded to the survey, which calculated for a response rate of 15.9%.



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- Part of the survey was the friends and family test (FFT), which asked patients how likely they were to recommend the hospital to friends and family if they needed similar care or treatment. The answers for the third and fourth floors in 2016 ranged from 94.1% to 100%, the average was 97.5%.
- We observed that patients' privacy and dignity were respected in theatres as well as on the wards.

Understanding and involvement of patients and those close to them

- We saw staff explaining to patients and their relatives the care and treatment that was being provided. Patients informed us that they were given sufficient information both pre and post procedure.
- Patients and their relatives told us that they could ask staff about their care and treatment. The patients we spoke with felt well informed about treatment, plans and costs.
- Patients were made aware of hospital fees before admission. Staff were knowledgeable about fees and could answer most questions about costs as well. One patient told us that there were "no surprises" about costs as she felt very well informed.
- Patients' rooms had their consultants' names on the front, so all patients knew who their named consultant was. Each room had a wipeable board with the names of staff looking after them written up.
- Patient feedback results from 2016 showed that 99.3% of inpatients and 97% of day case patients had confidence in their doctors. A total of 1498 patients responded to the survey.

Emotional support

- All the patients and relatives we spoke with told us they felt supported throughout their journey. Patients said the support provided by staff from consultation, pre-assessment and surgical intervention was very good. Patients told us that this included both the clinical and non-clinical staff.
- Patients had access to psychological support through the provider's psychological support team.

- Staff knew how to access multi-faith spiritual support through the spiritual care co-ordinator for patients and relatives. Chaplains visited patients and their families on request. Patients had access to different faith leaders upon request.

Are surgery services responsive?

Outstanding



Service planning and delivery to meet the needs of local people

- The range of surgical services had been developed in response to patients' demands and the specialties of the consultant surgeons using the hospital with practicing privileges. The service mainly offered in-vitro-fertilisation and gynaecological procedures, followed by orthopaedic surgeries, for example hip and knee replacements or spinal procedures.
- Surgical services provided care to elective patients whose admissions were planned in advance. The day surgery ward on the third floor accommodated patients after uncomplicated procedures, who were suitable to be discharged on the same day.
- As most of the surgeries that took place were elective, the admissions were staggered throughout the day. This was in order to mitigate against busy times in the day surgery unit, improving patient experience and reducing waiting times. Patients on the afternoon theatre list would be advised to come to hospital at midday, for example.
- The department offered elective surgeries on Saturdays. This accommodated patients who worked during the week, for example. The Saturday operating lists were regularly used by general and orthopaedic surgeons, but were available to all consultants.
- During periods of reduced activity, the day surgery unit would remain closed. For example, it would usually close for two weeks during summer or around Christmas.
- The hospital had one service-level agreement (SLA) within the surgical division. This was with a local unit for the supply and storage of human tissue.



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Access and flow

- Patients were seen by consultants with whom surgeries were decided. Once a date for surgery was agreed, the consultant's secretary sent the booking form and clinical letter to the reservations team and the pre-operative assessment clinic.
- The hospital informed us they did not routinely audit waiting times, as patients did not have to wait and were able to choose their preferred date of surgery. One of the consultants told us about how he was able to book one of his patients for urgent surgery within hours after making the decision to operate.
- In the 12 months prior to our inspection, the service had not cancelled any procedures for non-clinical reasons.
- Bed management meetings were held daily to ensure there were sufficient beds and staff for the expected admissions and any issues were discussed. This approach facilitated the identification of any issues, such as shortage of staff or beds, which could delay admissions. We observed one of these meetings, which was attended by the ward managers and sisters and theatre lead practitioner.
- The discharge process was thorough and clear. This meant that patients on the day surgery unit could leave the hospital hours after the procedure. Prior to the procedure, the nurse would discuss discharge planning. After the procedure, the consultant would discuss the outcome of the surgery with the patient. The patient would then receive a discharge pack that included a clinical letter that they could share with their GP. It also contained personalised advice regarding dressings, bathing instructions, discharge pain medication information, general information about the ward and a card with telephone numbers to call in case of queries.

Meeting people's individual needs

- The majority of admissions for surgical procedures were elective and planned in advance. Admission was facilitated in a timely manner and could be arranged at short notice to meet patient's individual needs and ensure they received treatment as soon as possible. For example, hospital staff told us that a superstitious patient was given a surgery date of preference according to her horoscope.
- Dementia training was mandatory; staff had completed dementia awareness training to enable them to care for people living with dementia. Staff who had attended a full dementia training day titled 'Dementia – Fit for the Journey' were the established dementia champions for each area of the hospital. The 20 dementia champions on the wards, theatres and recovery were recognisable through a badge on the uniform. The hospital utilised a dementia pathway, which was on display on the wards and also available in the policy library. It was based on NICE guidelines and included the "Forget me not" scheme to help staff recognise someone with memory problems or confusion. "This is me" booklets were produced to ensure staff were familiar with the best ways to approach caring for each patient.
- The learning difficulties lead was the CNO. Hospital passports were in use for patients with learning disabilities. Staff told us about a patient with learning difficulties who recently underwent surgery. Staff called the patient's care home and family in advance to obtain all necessary information regarding his care and habits. Before admission, the patient's special needs were communicated to theatre and ward staff in team briefings. The mother was allowed to come to the anaesthetic room with the patient to reduce anxiety. The family's feedback was: "We did not realise that care like this still existed. Thank you for treating him like an individual, he has not experienced such care in years."
- Patients commented on the excellent quality and wide choice of food, which met the needs of groups of patients from a variety of religious and cultural backgrounds. The menu offered an extensive range of different starters, mains, desserts, snacks and sides, patients were asked to choose from. The catering team was available for patients and ensured individual needs/requests were met wherever possible. Staff told us about a patient who requested organic food and how the chef found a supplier to provide the patient with organic meals. Patient feedback results showed that 91.8% of inpatients and 92.3% of day case patients were satisfied with the catering in 2016. A total of 1498 patients responded to this survey (response rate of 15.9%).
- Staff could access interpreters for patients who did not speak English by contacting in-house interpreters, or through telephone interpreting service.



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- There was step-free access in both the theatres and wards. All inpatient rooms had step-free access to bathrooms.
- Patients had call bells in their rooms. We saw call bells being answered promptly by staff and patients we spoke with confirmed this. An audit conducted in July 2016 showed that 96% (level 3) and 90% (level 4) of patients waited under two minutes for a response. A further 3.7% (level 3) and 8% (level 4) of patients waited between two and five minutes, with 0.3% (level 3) and 1.4% (level 4) waiting up to ten minutes. The hospital's target was 90% compliance with a call bell response within two minutes.
- The wards were able to facilitate a family member spending the night in patient rooms, if requested.
- The orthopaedic nurse specialist offered a helpline and gave orthopaedic patients her mobile number in case they had any questions after discharge. However, this was not offered to patients when she was on leave.
- The theatre manager told us about a patient who requested to keep the hip bone after a hip replacement. The team took pictures of the replaced hip with the theatre camera system and produced a booklet for the patient to take home. The theatre manager told us that the patient was very happy about this and allowed the team to safely dispose of the bone.
- The ward manager told us about how they allocated one of very limited spaces in the hospital's car park for a patient's relative with reduced mobility.

Learning from complaints and concerns

- Patients were aware of how to raise concerns. Information on how to make a complaint was provided as part of the patient information pack on admission.
- Staff told us that, where possible, they would resolve any issues with patients informally, prior to a formal complaint being made. There was an expectation at the hospital that any concerns raised by patients on the wards would be addressed immediately by the manager, and if possible, resolved immediately to patients' satisfaction.
- There were 28 formal complaints attributed to surgical care within the reporting period (October 2015 to September 2016), of which 96% were responded to

within the 20 day timeframe. The majority of complaints (64%) were related to nursing care, followed by consultant care (21%). One of the changes from complaints was a reduction of variability of agency staff on the wards with the aim to improve consistency of care.

- The chief executive officer (CEO) was responsible for complaints management with the chief nursing officer (CNO) taking responsibility for the day-to-day administration of patient complaints. Complaints were investigated in collaboration with the governance team.

Are surgery services well-led?

Outstanding



Leadership / culture of service related to this core service

- A theatre manager was responsible for theatres, a ward manager was responsible for the day surgery unit and a matron managed the wards on level four and five. All managers were supernumerary and reported to the CNO. Staff informed us they had good access to the managers as they were very visible on wards and had their offices adjacent to the nurses' stations.
- Local leaders were driven to improve the service and quality of care for patients. They demonstrated solid knowledge about their managed areas and the department and were able to give examples of recent and planned improvements. Staff spoke very highly of the support the matron, the ward and theatre managers provided across the surgical unit to the whole team. Staff of all levels told us they felt valued as team members. Staff told us they felt listened to, and any concerns they raised were acted on by managers. They felt confident about challenging poor practice if necessary, and were aware of the whistleblowing policy and procedure.
- The senior management team was highly engaged with the service. The CEO and CNO undertook regular walk arounds throughout the surgical division. Medical staff told us that the CEO and medical director were very supportive and always available. Consultants we spoke



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with praised the leadership and flat and responsive management structure. One consultant informed us that he required a new piece of equipment and was provided with it after few days.

- The staff survey 2016 demonstrated that 91% would recommend the hospital as an employer. This showed an increase to the previous staff survey in 2014. A total of 125 employees responded to the survey, which calculated to a response rate of 35%.
- Medical and nursing staff praised their good working relationship and teamwork. One consultant referred to nurses as being “phenomenal”. A surgeon told us that “staff know what they are doing”. Consultants we spoke with praised the supportive and close working relationship with colleagues and the “very cohesive consultant body”. There was a ‘buddy’ system in place for new consultants working at the hospital.
- Staff told us about good career development opportunities that were available. Motivated staff would be supported by managers to progress. The hospital allowed time and funding for courses. For example, a surgical first assistant course was available for theatre staff. One health care assistant in theatres told us that he started as porter and had been encouraged and supported in his career development. One pharmacist received support to complete the pharmacy clinical diploma, and received training in the delivery of clinical pharmacy services within the intensive care setting. Pharmacy technicians were also supported to become accredited checking technicians, and were deployed on the ward specifically to use this skill.
- Recovery staff told us that if they had to stay at work longer, they would be compensated with time off.
- The wards had an allocation board in the treatment room with information who the bleep holder was, nurse in charge and responsible person for equipment checks. The board was updated daily after the morning nurse briefing and also included a thought of the day, for example “together everyone achieves more”.

Vision and strategy for this core service

- The hospital’s vision was ‘exceptional people, exceptional care’. The hospital endeavoured to achieve this through their strategic framework. This involved delivering the highest quality of care, improving access

and convenience, driving operational excellence, strengthening doctor and partner relationships, becoming the patients’ provider of choice and developing comprehensive service lines.

- The hospital’s values were publicised across the hospital. For example, they were displayed on the wards and corridors. The values were: to recognise and value everyone as unique and individual, to treat people with compassion and kindness, to act with absolute honesty, integrity and fairness, and to trust and treat one another as valued members of the HCA family with loyalty, respect and dignity.
- All staff we spoke with were aware of the hospital’s vision and values. While observing and interviewing staff, we found that values were clearly embedded in daily practice and that staff were focussed on patients’ comfort and wellbeing.
- The hospital had developed the training programme ‘Project World Class’, which aimed to improve quality customer service, in addition to professional coaching and team work teaching sessions. All staff were involved in the training to improve patient interaction, which included role-play exercises.
- There was no separate vision for surgical services but staff were aware of their department’s strategy and goals to expand and improve the service and increase revenue.

Governance, risk management and quality measurement

- There was a defined governance and risk management structure, from corporate provider level, to hospital and departmental level. There was also a designated reporting structure for quality and risk management.
- There was a surgical services risk register in place, overseen by the clinical governance committee. The risk register was well-maintained and contained details about the risk, controls in place and additional measures to reduce risk. All risks were red-amber-green rated and dated. Senior managers were aware of these risks. One of the risks involved not being able to move the bed out of certain patient rooms due to the size of



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the corridor. Measures in place were to place low risk patients in those rooms, notice boards in the rooms to remind staff that beds could not be moved and make all staff aware during induction.

- The complaints and incident review group held weekly meetings, attended by heads of departments and governance team. They provided feedback to newly implemented CLIP (complaints, litigations, incidents, patient feedback) meetings, which in turn escalated to the weekly senior management meeting. The reason behind new weekly CLIP meetings was to be able to review issues more focussed in a smaller group and discuss and disseminate learning within a week.
- There was a medical advisory committee (MAC) in place. The MAC remit included clinical governance, reviewing practising privileges of all consultants, reviewing key performance indicators and advising management.
- The theatre manager attended the hospital's quarterly ethics meetings where, among other topics, behavioural issues of consultants would be discussed.

Public and staff engagement

- Staff told us the hospital allowed flexibility for staff with childcare responsibilities on a regular and individual basis.
- The staff survey in 2016 showed an employee engagement index of 78%, which was an improvement compared to the previous survey in 2014. Of those respondents, 97% were committed to doing their very best for HCA and 88% were proud to say they work for HCA. A total of 125 employees responded to the survey.
- Patients were provided with a patient survey on admission to the wards. They were able to fill it in and post it to the head office. The hospital employed a company to analyse and report on patient feedback. The report was sent to the hospital's quality and risk board, who addressed any issues raised by the report. Senior staff we spoke with were aware of latest trends of patient feedback and gave us examples how change was implemented to achieve improved patient experience.
- A patient experience working group met quarterly and results of patient feedback surveys were discussed among other related topics.

- Consultants participated in regular meetings with GPs, organised by the hospital to strengthen collaborations and reputation.
- The hospital had an 'employee of the quarter' scheme and staff received a lunch voucher and personal email from the CEO if they had been personally mentioned in positive patient feedback.
- Staff in leadership roles undertook mindfulness training in July 2016 to support in stress management and self awareness. The course addressed mental wellbeing and coping with day to day challenges. It was aimed to encourage senior staff to develop reflective strategies to deal with work pressures, to highlight the importance of how emotion affects behaviour and to help senior staff reflect on their sense of purpose at work, and consider how to facilitate their staff in achieving theirs. Attendees commented on how the course had given them a fresh perspective on everyday challenges.

Innovation, improvement and sustainability

- The surgical service offered a minimally invasive hip replacement, with a new anterior approach. This required special equipment, which the hospital provided. It allowed patients to walk the following morning and shortened recovery time. Theatre staff we spoke with were very excited about being part of this.
- The hospital offered a mesothelioma surgery service. A multi-disciplinary team including experts in the field of mesothelioma treated patients, utilising modern technologies.
- The service offered shoulder arthroscopy under local anaesthesia. Patients did not have to undergo general anaesthesia, but were able to stay awake and received a peripheral nerve block to numb the shoulder. This shortened recovery time. In the UK, shoulder arthroscopies are usually performed under general anaesthesia.
- Two theatres were equipped with an integrated camera and monitor system. This meant surgical procedures could be recorded or live streamed to the hospital's boardroom for teaching purposes or presentations.
- The hospital was piloting the use of a 'sepsis 6 trolley'. This trolley included all the medicines, equipment and documentation forms necessary to start treatment quickly in a patient with suspected sepsis.



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- Pharmacy staff had researched an electronic medicines administration system already in use in the United States that had the potential to reduce patient risk. As a result, they conducted a 6 month pilot of the barcode medicines administration (BCMA) system. Pharmacy staff spent numerous hours barcoding all the medicines in the hospital. Once complete, nurses scanned the medicines barcodes prior to medicines administration. A computer system captured all the medicines details.

The point of the system was to reduce medicines errors related to dispensing and administration. Analysis of the pilot phase showed that this system had the potential to reduce risk, but would work better with an electronic prescribing system. A business case related to this project was being developed. Once implemented, the system would be able to flag medicines allergies and help to reduce the number of medicines errors.

Critical care

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

Are critical care services safe?

Good 

Incidents

- There were no never events in critical care between October 2015 and September 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff told us they felt they could submit incident reports within a “no blame” culture that recognised human error sometimes occurred and they would not be blamed for this.
- The critical care unit reported 110 incidents between January 2016 and December 2016, of which 95% resulted in no or low harm and 5% resulted in moderate harm. The unit monitored and tracked incidents as part of quarterly quality and safety monitoring and from looking at the minutes of meetings and speaking with staff we found evidence the critical care head of department investigated incidents in the department and involved staff in the outcomes. The most commonly reported incident type was access, appointment, admission, transfer or discharge, which made up 42% of all incidents. Other incidents included implementation of care or ongoing monitoring (9%) and infrastructure including staffing and facilities (4%).
- Learning from incidents led to improvements in practice and safety standards. For example, one incident involved a patient who received an incorrect chest drain

procedure during a transfer to the critical care unit. The senior team found differences in RMO training during the investigation and as a result standardised transfer protocols and ensured all RMOs were familiar with them. An incident report relating to a nurse handover helped staff identify a number of areas for improvement in how handovers were structured. As a result staff developed a new handover protocol that meant patient observations and test results were always reviewed. We saw this in practice during our inspection and there had been no further incidents. We saw the provider adhered to the principles of the duty of candour in their response to this incident, including a discussion with the patient and an honest account of what happened.

- Pharmacists provided support following incidents relating to medicine errors. Where an incident involved a medicines management issue, the pharmacy team received a copy of the electronic report and worked with the senior nursing team to investigate it.
- A multidisciplinary team of senior nurses, a registered medical officer (RMO), consultants and a pharmacist joined a weekly incident review meeting. The multidisciplinary approach to investigating incidents meant staff from different specialties provided guidance and learning. For example, following an incident out of hours in which a modified release medicine was administered instead of an immediate release version, the pharmacy team sent out updated guidance for staff and conducted spot checks of practice
- Senior clinical staff conducted monthly morbidity and mortality (M&M) meetings that reviewed patient care and outcomes. RMOs attended M&M meetings where they had cared for a patient included in a review to provide input and identify areas of good practice and for learning. We looked at the minutes of M&M meetings



Critical care

between February 2016 and November 2016 and saw in each case the meeting was well-attended by the multidisciplinary team that had cared for the patient and the treatment provided was reviewed in each case.

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

- A quality dashboard was produced quarterly to monitor the provision of harm-free care including through the monitoring of incidents such as pressure ulcers and falls. The clinical governance committee reviewed the dashboard quarterly and staff were involved in this through team meetings.

Cleanliness, infection control and hygiene

- As part of quarterly environmental infection control audits, the unit scored 100% compliance in hand hygiene audits between September 2015 and November 2016. In November 2016 the unit implemented monthly observational hand hygiene audits to supplement the quarterly reports. Between November 2016 and February 2017, the unit achieved an average of 97%, including two months of 100%. Although this was better than the hospital's target of 95%, the critical care manager implemented an action plan to more consistently achieve the maximum of 100%. The action plan was due for completion in April 2017 and included elements such as increased supervision and training of staff from infection control link practitioners.
- Between October 2015 and September 2016, there were no instances of meticillin-resistant staphylococcus aureus (MRSA), meticillin-sensitive Staphylococcus aureus (MSSA), Escherichia coli (E-Coli) or Clostridium difficile (C.Diff) in critical care.
- A dedicated housekeeper was assigned to the unit and had undertaken specialist training to enable them to provide a safe service that adhered to the infection control policies in place.
- An infection control link nurse was in post and liaised with the hospital link practitioners, undertook additional training and supported colleagues with infection control practice.
- Staff used bright green 'I am clean' stickers to indicate when an item of equipment had been cleaned and disinfected and was ready for use. During our inspection we observed staff use this system consistently.

- Each bed space had disposable curtains around it for privacy and staff changed these every six months for infection control, or sooner if they were contaminated.
- We saw staff used alcohol gel when entering the unit and moving between clinical areas and they washed their hands before and after patient contact. We also staff wash their hands at appropriate times. A patient and a relative said to us that they had noticed good hand hygiene practice from all of the staff they had interacted with.
- Nurses completed damp dusting of equipment in each bed space or private room when occupied by a patient. We saw this was recorded in the patient's electronic record to enable the team to track cleanliness and infection.
- Between October 2015 and September 2016, the unit scored 100% in quarterly hand hygiene audits.

Environment and equipment

- A quarterly environmental infection control audit took place to assess the unit against 23 standards and criteria, including all clinical and patient environments, waste disposal, central line insertion and management and the use of personal protective equipment (PPE). Between September 2015 and November 2016, the unit met or exceeded the hospital minimum target of 95% in every criteria and on every occasion except one. Overall the unit achieved 100% compliance on 82% of occasions. Infection control in relation to equipment, utility rooms and patient bathrooms and the use of PPE was scored consistently at 100%.
- The unit audited the use of high impact intervention bundles, including the urinary catheter care bundle, the ventilator bundle, the tracheostomy bundle and the central venous catheter bundle. In 2016, overall compliance was 95%, including 100% compliance in the tracheostomy care bundle.
- The unit had four single occupancy rooms for level three patients and a two-bedded bay for level two patients. The unit had audited compliance with the Department of Health, Health Building Note (HBN) 04-02 by completing a gap analysis. This HBN relates to access, bed spaces, access to adjacent units and staff offices. The unit was fully compliant with the HBN with the exception of some ceiling clearance spaces that were 0.3m lower than the minimum recommended height. This was due to the listed status of the building, which



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meant the organisation could not undertake major structural changes. In addition, there was no risk to patients as a result as staff had adapted the clinical environment to take this into account.

- A senior staff nurse was the unit's lead for equipment and was responsible for organising maintenance and identifying new items for the service. This individual also provided training and one-to-one education to other clinical staff on the use of specific items of equipment.
- A rolling programme of maintenance and calibration was in place for medical and therapies equipment and there was a 24-hour on-call repair service available for medical equipment that failed.
- A stock rotation system was in place for consumable items although this did not always identify items immediately when they expired. For example, three central urinary catheter insertion packs, a central venous catheterisation set, six catheters and eight bag access devices expired the week of our inspection and had not been disposed of. However, we saw staff checked expiry dates before using any items and a stock rotation check had not yet taken place the week we were on site.
- Physiotherapists provided one-to-one support for nurses to use new rehabilitation equipment that had been sourced for specific needs.
- The environment was visibly clean and staff adhered to national guidance in safety processes. For example, sharps bins were stored above floor level with closed apertures and with signed and dated labels.
- Two negative pressure rooms were available and the pressure systems were maintained in line with manufacturer guidance.
- Emergency equipment on the unit included a resuscitation trolley with defibrillator, suction unit and oxygen and a difficult airway trolley. The trolleys were fully stocked and staff had documented daily safety checks on each throughout the three month period we checked.
- The unit contributed to a quarterly environment and equipment audit that established quality and safety using Infection Prevention Society quality improvement standards. The audit included the condition of all areas of the unit, waste management processes, the use of isolation protocols and the disposal of sharps. Between October 2015 and September 2016, the unit scored an average of 97%. This was better than the hospital's target of 90%.

Medicines

- A pharmacy team dedicated to the unit provided daily service to the unit including for medicines management and prescription support. The service used an electronic prescribing service that ensured accuracy and efficiency. The pharmacy team met the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommendation that there should be 0.4 whole time equivalent (WTE) pharmacists for the number of critical care beds provided. The team also met the standard that pharmacy technical support be available at all times.
- In 2016, 13% of reported incidents related to medicine errors. This included inprescribing and administration. The critical care manager and pharmacy team worked together to investigate incidents and the pharmacy team provided one-to-one support and supervision for nurses after an incident.
- Medication administration records (MARs) were completed on the electronic records system. We looked at six MARs and saw they included a record of time of administration, the date and the person administering the medicine.
- Controlled drugs (CDs) were stored in a locked cupboard with restricted access, in line with national safety guidance. We looked at the documentation of CDs from October 2016 to February 2017 and saw two nurses checked the stock twice daily without exception. We also checked CD stock against the latest record book and found it to be accurate.
- Staff audited CD compliance quarterly against 23 quality and safety standards. Between July 2016 and September 2016, critical care had 86% compliance. Three areas were identified for improvement, including no obliterations on paperwork and signing and dating of errors. All three areas were found to be compliant in the audit between October 2016 and December 2016, in which the unit scored 90%.
- Intravenous fluids were stored in locked cupboards with restricted access to the rooms.
- Staff recorded temperature checks of fridges used to store chilled medicine daily. We looked at the records from October 2016 to February 2017 and found in all cases the fridge was maintained within the safe temperature range that meant medicines remained effective. Staff recorded a daily temperature of the treatment room used to store medicines. We looked at



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records for the two months prior to our inspection and saw they were completed in full and in all cases the temperature had been maintained within the safe storage limits of pharmaceutical guidelines.

- Critical care participated in the provider's monthly medication safety thermometer audit. Staff used this to monitor medicines management safety and to benchmark critical care against other inpatient areas. Between July 2016 and October 2016, 100% of patients had their allergy status recorded and 100% had a medicine reconciliation plan started within 24 hours of admission. In addition, 94% of patients had no doses of critical medicine omitted. Where an omission had occurred, this was a result of the patient declining a dose.
- The pharmacy team conducted a bi-annual antimicrobial stewardship audit in the unit to assess prescribing against antimicrobial guidance, which was in place to ensure antimicrobials were effective. In the previous 12 months the unit had patients who received antimicrobials during only one audit, in December 2016. In this audit the unit demonstrated 100% compliance with stewardship guidelines.

Records

- Critical care services were equipped with an electronic patient record system that enabled staff to access diagnostic results, order tests and monitor results. The multidisciplinary team had access to this system, which meant notes and reviews from all professionals were available at a single point of access.
- Staff completed a series of risk assessments on each patient's admission in line with Intensive Care Society guidance. This included risk assessments for venous thromboembolism, waterlow, malnutrition, falls and infection. We looked at a sample of six records and found staff had completed risk assessments consistently with appropriate updates depending on each patient's condition.
- The physiotherapy team had contributed to the development of the electronic system and it was compatible with the 'SOAP' notes system. SOAP is an acronym for 'subjective, objective, assessment, plan' and refers to the structured nature of each rehabilitation plan.
- Cardiac arrest recording sheets were kept on the resuscitation trolley and included a debrief record and documents to record post-resuscitation care.

- All of the staff we spoke with were positive about the electronic records system and said part of their training had been to make sure they retained their focus on the patient and not on the computer. We saw this worked well in practice.
- Critical care outreach nurses used an outreach proforma to document reviews and risk assessments for patients under their care on the wards. This enabled the team and ward colleagues to plan care and monitor risks.

Safeguarding

- Of the critical care team, including medical staff, 100% had undertaken safeguarding adults and children level two training as part of their induction and received updates to this depending on their level of responsibility and changes in the needs of the patient population. For example, staff had been trained to recognise and respond to specific signs of abuse, such as female genital mutilation (FGM). This included medical staff.
- A safeguarding link nurse was in post in critical care and worked with the provider's safeguarding officer and other staff in the hospital to ensure policies and practice met the latest national best practice standards.
- Critical care did not provide services for children but staff had child safeguarding training in recognition that relatives may bring children into the unit. All of the staff we spoke with were aware of their responsibilities with regards to this and demonstrated detailed knowledge of the principles of child safeguarding and the Fraser guidelines.

Mandatory training

- Mandatory training included infection control, safeguarding, conflict resolution, moving and handling and information governance.
- RMOs completed mandatory training as part of their induction process and were offered regular updates according to the provider's training programme.
- At the time of our inspection, 100% of staff were up to date with mandatory training in equality and diversity, infection control, information governance, manual handling and safeguarding adults. Overall training compliance was 97%.

Assessing and responding to patient risk

- A critical care outreach nurse was available in the hospital at all times and provided urgent care and assessment to patients whose condition deteriorated.



Critical care

The critical care resident medical officer (RMO) supported the outreach nurse and worked with the RMO responsible for the inpatient wards and surgery when needed.

- An up to date escalation policy was in place for staff to use in the event a patient deteriorated and to manage emergency admissions. All of the RMOs and nurses we spoke with demonstrated knowledge of this and a consultant intensivist was always available on call to review emergency admissions.
- An emergency transfer policy was in place that staff could use in the event a patient deteriorated and needed to be transferred to an acute hospital. This policy had not been previously used but staff demonstrated knowledge of the procedure to follow and the policy was up to date.
- The senior clinical team reviewed critical care outreach patients every day as part of an operational site meeting. In addition, the RMO met twice daily with the nurse in charge and outreach nurse for a safety briefing to review patients.
- A sepsis trolley was available in the unit and was fully stocked with all items in-date and with documented daily safety checks. Staff were trained in the use of the sepsis six pathway, a copy of which was stored with the trolley.
- The critical care and general RMOs, outreach nurse and critical care manager formed the on-call resuscitation team and met daily to review patients at risk.
- Staff used a monitoring tool in the electronic patient record system to monitor levels of sedation, which we saw RMOs used consistently and at intervals individualised to each patient. This system included the Confusion Assessment Method for Intensive Care Units (CAM-ICU), which staff used to monitor rates of delirium. We saw this in use in the records we looked at.
- Critical care outreach nurses monitored patients on the wards using a remote electronic vital signs system. This enabled them to identify quickly when a patient might be deteriorating, alert the ward staff and provide a rapid response. Ward nurses used the national early warning scores system to monitor deteriorating patients and the critical care outreach nurse monitored the scores to ensure they were completed accurately and to identify reasons for their deterioration.
- The two-bedded high dependency bay was equipped with facilities to provide safe care and treatment for

level three patients, including ventilation and life support for more than one organ. This meant the unit could provide additional capacity in the event patients in the hospital deteriorated unexpectedly.

- All staff nurses were trained in immediate life support and the senior nursing team were trained in advanced life support.

Nursing staffing

- A critical care nurse manager led a nursing team of 16 sisters, outreach nurses, senior staff nurses and staff nurses. Each shift had a supernumerary senior staff nurse in charge. Nurse staffing levels consistently met the standards set by the Faculty of Intensive Care Medicine (FICM) and Intensive Care Society (ICS) Core Standards for Intensive Care Units. This meant level three care was provided by a nurse to patient ratio of 1:1 and level two care was provided by a nurse to patient ratio of 1:2.
- There were four nurse vacancies, which was 25% of the established number of nurses needed to fully staff the unit.
- A senior nurse on each shift with training in the management of deteriorating patients provided a critical care outreach service, which operated 24-hours, seven days a week.
- The critical care manager planned nurse staffing in advance based on elective admissions and reviewed this twice daily to ensure it met patient needs. Additional nurses could be assigned at short notice in the event of an emergency admission from the ward or from theatres.
- Bank and agency nurses completed an induction from the critical care manager before they were able to work in the unit. They also had immediate access to the electronic patient records system, which meant they could access test results and record observations.
- We observed a nurse handover and saw it was structured and interactive and each nurse was involved in planning patient-specific care for the day. The team discussed each patient in detail and included consideration of their social and psychological needs as well as their medical condition. We also observed a handover between the senior nurses in charge. This included admission and discharge planning and a comprehensive review of each patient's observations overnight as well as their latest blood results, fluid intake and dietary requirements.



Critical care

- The critical care outreach team met daily for a morning safety brief, which included a review of all patients. The outreach nurse, critical care RMO, hospital RMO and hospital duty sister attended this and allocated cardiac roles. The consultant intensivist joined this safety brief when appropriate to the needs and acuity of patients.

Medical staffing

- A team of four consultant intensivists led medical care in the unit, including twice-daily ward rounds, consultant-led admission and a consultant review within 12 hours of admission. In addition the consultant and RMO conducted a late-night ward round as an extra observational review. All consultants were accredited by FICM. This meant consultant cover met the national standards of the ICS.
- Consultant cover was provided on-site between 8am and 8pm seven days a week. Out of hours consultants were available on-call and could provide virtual clinical decision-making through remote access to the electronic patient record system.
- A team of four RMOs provided 24-hour cover in the critical care unit and supported the critical care outreach nurse. RMOs worked 24-hour shifts and the senior hospital team used an electronic rostering system to ensure this was never exceeded. We spoke with three RMOs and looked at the duty rota for a four month period. We found the 24-hour shift system had not been breached at any time.
- A consultant intensivist was on-call and available to reach the unit within 30 minutes during out of hours periods, which met the safety standards of the ICS. We spoke with three RMOs who were positive about their relationships with consultants and the escalation process. One RMO said, “We have a low threshold for getting consultant help. If there’s anything we’re not sure about, we call them. They are very receptive to this and there’s never been a time we can’t get hold of the duty consultant.”
- Handovers took place between RMOs at every shift change and twice daily handovers took place between the RMO and consultant. We observed a handover between RMOs and saw it was detailed and patient-centred. For example, RMOs considered each patient’s social needs, support at home and family relationships when planning the next stage of their care, including discharge.

Emergency awareness and training

- All staff had undertaken fire and evacuation training in the year prior to our inspection. This included practical training in the use of evacuation chairs and slide sheets, which could be used to evacuate immobile patients. Staff we spoke with demonstrated knowledge of their responsibilities in an emergency, including their immediate actions and how to use a ‘cascade’ communication system. Both horizontal and vertical evacuation routes were available from critical care and staff demonstrated accurate knowledge of both.
- There had been a fire in another area of the hospital within the previous 12 months and staff had discussed this in meetings to identify areas they could use to learn from.

Are critical care services effective?

Good



Evidence-based care and treatment (this core service only)

- Policies and procedures were available on the hospital intranet system and staff demonstrated they had access to these. Temporary staff, such as agency nurses, also had access to this system. Policies specific to critical care reflected national guidance, including from the Faculty of Intensive Care Medicine (FICM), the National Institute of Health and Care Excellence (NICE) and the Intensive Care Society (ICS). This included sepsis guidance and access to the national sepsis six pathway.
- A gap analysis against FICM core standards highlighted overall high levels of compliance, with two exceptions. One exception was that the daily ward round did not include direct input from microbiology. Instead, microbiology reviews were weekly and staff had on-demand access to a microbiologist at all times. In addition, dietetics input was available three days per week instead of seven days per week. The critical care manager had submitted a business case to recruit a dedicated full time dietician.
- Staff documented a daily assessment of delirium for each patient, which was repeated more regularly if needed. This was in line with ICS core standards for critical care.



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- Staff used a programme of 10 local audits to assess and benchmark care and treatment. Audits were repeated at least quarterly and included quality of discharge summaries, the use of early warning scores for deteriorating patients, discharge times and management of central venous catheters.
 - The critical care unit was part of the NHS North West London Critical Care Network. This meant they benchmarked quality standards of care and patient outcomes against other units in the network.
 - Staff had access to standard operating procedures for urgent situations and clinical emergencies, such as a major haemorrhage.
 - The physiotherapy team conducted a bi-monthly notes audit that they used to review decision-making and analyse the rehabilitation decisions made for each patient.
 - Patients received physiotherapy in line with ICS and NICE guidance, which included a minimum of 45 minutes of therapy per day.
 - Staff used national guidance for resuscitation, which was printed and readily available by emergency equipment. This included Resuscitation Council (UK) guidelines, emergency algorithms for life support and defined roles for each person in a resuscitation situation.
 - The nurse audit lead had implemented an annual critical care unit equality and report schedule to supplement the quality measures provided by the provider's corporate audits. This comprised a series of audits based on the ICS national core standards that patients must be reviewed by a consultant intensivist within 12 hours of admission, undergo twice daily consultant-led reviews and have a physiotherapy assessment within 24 hours of admission. The audits were repeated quarterly and an action plan put in place to address any areas of underperformance with the results discussed with staff at team meetings.
 - Staff were proactive in developing and implementing local audits to establish expected levels of care and to improve clinical practice. For example, following a number of instances where medicines were prescribed without a co-signature, staff were offered the opportunity to undertake additional medicine training and to achieve a competency certificate. The certificate was awarded after staff were audited in their medicine administration practice and required each individual to achieve 100%. This included nurses and registered medical officers (RMOs) and led to significantly improved practice, with no medicine administration errors relating to signatures as a result.
 - Critical care outreach nurses performed continuous monitoring of the completion of fluid charts for inpatients on the wards. This was in response to some instances where patients who deteriorated did not have consistent fluid monitoring in place.
 - The audit lead completed a quarterly audit of the completion of risk assessments in patient records including venous thromboembolism, malnutrition, manual handling and falls. The latest available results were from the period July 2016 to December 2016 and demonstrated 100% adherence to risk assessment criteria in all seven measures.
 - Infection control link practitioners conducted quarterly safety audits of five infection control high impact interventions to benchmark standards against NICE clinical guidance 139. Between October 2015 and September 2016, the unit achieved 99% compliance against a hospital minimum standard of 90%.
- ### Pain relief
- Staff provided care in line with the Royal College of Anaesthetists Faculty of Pain Management Core Standards for Pain Management Services in the UK. This included continual pain assessment, appropriate consultant intensivist review and patient-controlled analgesia (PSA) where appropriate. We saw records that evidenced this and also included the appropriate prescribing of analgesia.
 - Critical care outreach nurses administered PSA for ward based patients following discharge from critical care and easy-ready information was available for patients with regards to this.
 - In October 2016 the provider had audited pain relief to benchmark standards against the assessment and management of acute and chronic pain best practice guidelines. This included six checks such as an immediate pain assessment on admission, reassessment of pain during intentional rounding episodes and appropriate clinical response to increasing pain. Critical care achieved 100% in the audit, which was better than the provider's target of 90%.
- ### Nutrition and hydration



Critical care

- A dietitian was available on-site Monday to Friday and provided reviews of patients who were fed through intravenous lines or total parenteral nutrition. The dietitian also provided general nutrition advice and prescribed diet and feeding plans for patients who were at risk of malnutrition.
- A head chef led a specialty catering team on-site, who were able to prepare fresh meals to order to meet complex dietary needs of patients. The dietitian and catering team liaised in complex cases to ensure patients received appropriate nutrition.
- Nurses used the malnutrition universal scoring tool and a fluid balance chart to monitor patients for the risks associated with malnutrition and dehydration. We saw evidence of these tools in all of the records we looked at.

Patient outcomes

- A nurse was the audit lead for the unit and allocated 50% of their time to audit development, implementation and results.
- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC), which enabled staff to collect data and benchmark performance against other units nationally. Between April 2016 and September 2016, there had been no deaths in the unit and no unplanned transfers out or transfers for non-medical reasons. In addition, there had been no transfers to the wards between 10pm and 7am, which is recognised as being associated with poorer outcomes for patients. This meant the unit performed significantly better than other similar units in the network. For example, the unit had a 0% mortality rate for patients considered to be high risk and who were admitted from the ward. Similar units had a 2.9% mortality rate for the same type of admissions and the overall average was 9.4%.
- A consultant intensivist led a critical care post-discharge support programme (PDSP) that was based on a holistic model of care. This meant the service provided support for improved physical health and wellbeing as well as for psychological health. The PDSP had resulted in identifying a patient who had developed post-traumatic stress disorder after discharge. Staff had provided an appropriate referral for the patient and used learning

from this to more readily monitor psychological health in the hospital. In addition, the lead consultant used the follow-up time to encourage patients to maintain their rehabilitation plan.

- Critical care was equipped to provide invasive and non-invasive ventilation support and all nurses were trained in this.
- Physiotherapists reviewed patients within 24 hours of admission and provided a minimum of 45 minutes of daily therapy in line with national ICS guidelines.
- Physiotherapists worked with clinical staff to provide musculoskeletal rehabilitation to patients who needed support to be weaned.
- The critical care outreach team monitored patients for 48 hours post-discharge from the unit to a ward in line with ICS and NICE guidelines.

Competent staff

- All nurses had completed the provider's critical care foundation course and 76% had a post-registration qualification in intensive care nursing, which was better than the ICS target guidance of 50%. Agency nurses who worked in the unit were required to have this qualification before they were able to work shifts.
- A training needs analysis had taken place between November 2016 and November 2017. The clinical team used this to identify training needs in the unit as a whole and for individual members of staff. As a result simulation training was introduced every three months that included critical care staff, ward staff and the RMOs. The simulations took place based on case studies and involved targeted themes such as communication, handover and emergencies.
- In November 2016 and December 2016 critical care outreach nurses had undertaken training with the Network for Improving Critical Care Systems and Training. This included responding to deteriorating patients and clinical competency training through a series of simulations and scenarios.
- The hospital supported RMOs to complete ALS instructorship programmes, which meant they could provide ALS training to colleagues in the hospital.
- Consultants had invited local GPs to the hospital to a training day that focused on post-discharge care and treatment.
- We asked three RMOs about training and clinical development opportunities and we received positive feedback in each case. For example, one RMO said they



Critical care

were supported to take part in ICS meetings, write research papers and take study leave. One RMO said, “[The provider] supports me as much as I can; I’ve never been turned down for training.”

- Staff from multidisciplinary teams provided training and clinical competency support to critical care staff. For example, the pharmacy team provided training in the management of controlled drugs to senior nurses and joined a critical care training day to provide medicines management training.
- The critical care pharmacy team encouraged staff to engage in professional development and as a result a senior technician had been promoted to the post of accredited checking technician. This was part of a programme of expansion for the team that included the promotion of junior technicians to senior technicians and recruitment of new staff.
- All of the staff we spoke with from different disciplines and specialties spoke positively about their training opportunities. For example, nurses had provided a housekeeper with training to help them adapt to the clinical environment and the hospital provided chemical control training specific to critical care.
- Nurses adopted lead roles in specialist areas to help them develop skills and provide support and updates to colleagues. This included through presentations at training days and staff meetings. For example, a senior staff nurse was the lead for the electronic patient records system. This individual had undertaken configuration training to help the unit adapt the software to their specific needs and met every two months with other leads in the provider’s hospital network for group learning and troubleshooting. Nurse leads were also in post for infection control, diabetes, nutrition and dementia.
- Nurses and RMOs arranged shifts at other sites, including other hospitals in the provider’s network and in NHS acute hospitals, to ensure they maintained their specialist skills. This ensured they maintained clinical competencies in care and treatment they did not regularly provide in this unit as a result of the services provided. This rotation programme also contributed to motivation levels and helped nurses learn skills and techniques from their peers. For example, one RMO completed weekly clinical work with an anaesthetist to ensure they maintained skills in managing central lines. The RMO maintained a log book of this and tracked their skills.
- The unit had a practice development nurse post, which was vacant at the time of our inspection. The nurse manager and a senior staff nurse ensured staff maintained access to training and competency updates as an interim measure.
- RMOs received protected supervision time with consultant intensivists and were encouraged to pursue their own research and audit activities to develop clinical competencies and experience. The clinical lead supplemented this with opportunities for secondment to busier acute intensive care units, which enabled RMOs to develop in different environments.
- Physiotherapists who worked in critical care had undertaken specific clinical competencies in intensive care medicine in addition to their core competency framework from the Chartered Society of Physiotherapy (CSP). This team was sometimes supplemented by bank staff, who could only work in the hospital if they had also completed CSP competency training. This meant patients received a seamless service to the same standard from every therapist.
- Physiotherapists were expected to engage in service development and implement a new strategy or initiative as a result. This would then be audited to identify effectiveness.
- Each member of staff underwent an annual appraisal and personal and professional development plan. At the time of our inspection, 100% of staff in the unit had completed this in the previous 12 months.
- Nurses who provided the critical care outreach service had delivered scenario-based practical training to ward nurses in the effective management of deteriorating patients. This had led to improved communication between ward staff and critical care and meant patients who triggered a review on the national early warning scores system were reviewed more consistently.

Multidisciplinary working

- Two physiotherapists and an assistant physiotherapist provided daily support to patients. Physiotherapists conducted a daily handover with nurses and the RMO in critical care that enabled them to track the rehabilitation progress of patients who received long-term care.
- In all of the patient records we looked at there was evidence of regular multidisciplinary input, including from physiotherapy, dietetics and microbiology.



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- The pharmacy team had access to the electronic patient records system, including remote access and e-prescribing. This meant the team provided a responsive service 24-hours and could review and change patient prescriptions rapidly on referral from a clinician.
- A dedicated microbiologist conducted a weekly ward round and a centralised service meant staff had access to microbiology input at any time.
- A speech and language therapy service was available at a nearby hospital in the provider's network and staff could obtain an on-demand consultation seven days a week.
- A weekly multidisciplinary meeting was attended by clinical staff, physiotherapists, pharmacists, the dietician and other specialties if indicated by patient need. Speech and language therapy staff contributed to multidisciplinary reviews where the patient received total parenteral nutrition.
- The working ethos and focus on patient-centred care enabled staff in the multidisciplinary team to contribute to care planning and discuss changes with each other. For example, the physiotherapist said consultants were always flexible with them and if they wanted to change a physiotherapy care plan, they could work together to do so.
- Critical care and theatres used compatible electronic patient records systems and clinicians had access to both. This meant they could track patient procedures, care and treatment.
- A discharge summary was sent to each patient's GP the day they were discharged. We looked at three discharge summaries and found they were detailed and included the latest observations and test results.
- The critical care outreach nurse had access to patient's records and observations in advance of conducting ward reviews. This meant they visited patients with a full understanding of their current condition.
- For further detailed findings please see the surgery core service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received Mental Capacity Act (2005) training as part of their mandatory training and 100% of the critical care team were up to date with this. Staff demonstrated knowledge of this in relation to their responsibilities. All staff had been updated on the 2017 legal ruling and related advice from the ICS and Faculty of Intensive Care Medicine in relation to the use of the Deprivation of Liberty Safeguards in intensive care settings.
- Staff screened each person on admission for delirium, which meant they could identify any needs in relation to cognition as well as the effects of anaesthesia.
- We saw evidence from looking at patient records that staff documented consent or best interests decisions in the electronic patient record system. Staff also documented assessment of mental capacity and there was a policy in place to guide decision-making for patients who were sedated. This was a mandatory field, which meant staff could not save records unless this information had been included.
- In the 12 months prior to our inspection there were no applications for Deprivation of Liberty Safeguards in the unit.

Seven Day Working

- Consultant microbiology and anaesthetics services were available 24-hours, seven days a week through an on-call system.
- Medical cover was available in critical care and consultant specialists in urology, gynaecology and acute medicine were available on-call 24-hours, seven days a week for urgent support.
- Physiotherapy and occupational therapy services were available on-site seven days a week.
- Pharmacy services were provided 24-hours, seven days a week. This included on-site service between 8.30am and 7pm Monday to Friday and between 9am and 12.30pm at weekends. Outside of these hours a pharmacist was on call for dispensing and to offer clinical advice and care reviews.
- Diagnostic services including x-ray and magnetic resonance imaging (MRI) were available 24-hours a day, seven days a week.

Access to information

Are critical care services caring?

Good



Compassionate care



Critical care

- Staff provided care and treatment with compassion during all of our observations. For example in the high dependency bay staff ensured privacy curtains were always drawn around the patient before commencing an examination. We also saw nurses maintain conversation with patients and relatives and reassured them about what they were doing. Conversations were always interactive and staff encouraged people to ask questions.
- Staff had discharged one patient with flowers in their hair after they had built a relationship with them and understood that flowers contributed to their wellbeing.
- During our observations of care we noted staff always asked if a patient was comfortable or needed anything before they left the room or area. We spoke with a member of staff about this who said it was part of the ethos of the hospital that they never left a patient without offering a drink or checking if they needed anything.
- We observed a member of staff with a patient and their relative helping them to choose lunch. The nurse understood the nutritional needs of the patient and took their time to help them work through the menu to choose something that would be suitable and that they would enjoy.
- We spoke with a patient and their relative in the high dependency bay. Both individuals were positive about their experience in the hospital. The patient said, "I can't fault anything at all about the critical care unit. Everyone has been really lovely." Another patient told us they felt safe in the unit as a result of attention from staff. They said, "I know nurses have been checking on me during the night because they come in and touch my hand just to make sure I'm okay. They don't disturb me but I was reassured knowing they were there."
- Staff had taken part in a strategy to deliver a high standard of care, called 'project world class'. Staff we spoke with were positive about this and said they felt it had made a "real difference" to how they communicated and interacted with patients and relatives from diverse backgrounds.
- The latest critical care survey results related to the period July 2016 to November 2016 and indicated 94% of patients would recommend the unit and 100% rated their experience positively. In addition, 98% said staff treated them with courtesy and respect.

Understanding and involvement of patients and those close to them

- During our observations of care we saw staff explained to patients what they were doing and why they were doing it. For example, one nurse told a patient they were removing their oxygen to help them conduct an assessment of how they breathed without it.
- Staff involved patients and their relatives in decisions about their care. For example when a patient reached the ceiling of their care, a consultant helped the patient and their family to plan end of life care and transfer them to a more personalised and less clinical environment out of the unit.
- During our observations of resident medical officers (RMOs) and nurse handovers we observed staff discussed the views and wishes of patients and their relatives. This information was available to staff starting a shift because conversations were documented on the electronic patient record system.
- Staff built relationships with relatives to understand the needs of patients who received long term care. For example, one patient's relative told staff they enjoyed hymns and church music. In response staff played music and sing-along hymns to the patient each afternoon as part of their care and rehabilitation. Staff also invited the patient's relative to lunch every Friday as a way to discuss progress and ensure they were consistently involved in care planning.
- A consultant intensivist led a critical care post-discharge support programme (PDSP) that was based on a holistic model of care. This meant the service provided support for improved physical health and wellbeing as well as for psychological health. The PDSP had an international scope and patients who were discharged out of the UK had access to this by video link
- In addition to the critical care follow-up programme, staff had kept in touch with patients and relatives after they were discharged home, including to locations outside of the UK. For example, the nursing team met with one patient and their relative via video link to discuss their progress once they were home. This was indicative of the personalised relationships staff were able to build.
- Between July 2016 and November 2016, 98% of patients who responded to the critical care survey said they



Critical care

always had enough information about their condition and treatment whilst in the unit. In 92% felt staff had kept them up to date with their progress and 90% said they had felt able to ask questions of staff.

Emotional support

- Counselling and bereavement services were available for patients and relatives and these were proactively offered by staff. We saw evidence of this in patient records and from the examples staff gave to us.
- Alternative and complementary therapies were available to patients and the multidisciplinary team ensured these were offered only when it was safe to do so.
- The service communicated costs to patients ahead of an elective admission to critical care and ensured they were kept up to date with the costs of any additional diagnostics or treatment.
- Patients and their relatives had access to a 24-hour multi-faith chaplaincy service. Although a dedicated faith room was not available on site, staff were able to find quiet, private space for people on request.
- The consultant-led ensured patients had access to emotional support during follow-up discussions and the consultant could refer them to counselling services as needed. This included remote support when the patient had left the area.

Are critical care services responsive?

Outstanding



Service planning and delivery to meet the needs of local people

- Critical Care Unit (CCU) served a combination of specialities, including post-operative patients and medical patients. Patients could be admitted after elective or emergency operations or after becoming medically unwell on hospital wards.
- The CCU could flex patient distribution to respond to patient need. This meant the level two high dependency beds could be used for more complex level three patients.
- An accessible shower and bathroom was available on the unit and staff supported patients to maintain personal care and hygiene.

- All patient treatment areas had natural light, individual climate control and an individual television above each bed. A dry-wipe board was in place in every private room that enabled staff to display and track patient progress and rehabilitation. This provided a quick-reference guide for other staff involved in care and also acted as a motivating factor for patients and their relatives who could see the progress detailed.

Access and flow

- Between October 2015 and September 2016, the average occupancy rate of the unit was 37%. This reflected 122 bed days for level three patients and 693 bed days for level two patients.
- ICNARC data from April 2016 to September 2016 showed that CCU primarily admitted:
 1. Planned admissions following elective/scheduled surgery (81%).
 2. Theatre – admission following urgent or emergency surgery (8%)
 3. Ward or intermediate care area (8%)
 4. Planned or unplanned transfer from another critical care unit (2%)
- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) that enabled staff to collect data and benchmark performance against other units nationally. Between April 2016 and September 2016 100% of patients were discharged within four hours of the decision being made and there had been no delayed discharges. In the same period there were no unplanned readmissions within 48 hours of discharge.
- Between April 2016 and June 2016 the average length of stay for patients was one day. This reflected the case mix and acuity of patients admitted.

Meeting people's individual needs

- The critical care head of department planned staffing levels to meet the individual preferences of patients. For example, patients and their relatives were able to request care be provided by a male or female nurse. For international patients, the hospital worked with the embassies to ensure a smooth transition of care.
- Staff provided individualised care for patients who remained in the unit for longer periods of time. This included attention to detail such as helping one patient to style their hair and paint their nails with their



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favourite colour. Clinical staff had worked with the therapies team to help a family safely take a patient out of the unit in a wheelchair for short periods of time each day to help their motivation to recover. RMOs worked together to address the impact of past alcohol use on the future prognosis of a patient. This included a discussion of the patient's current social status, alcohol use and likelihood of recovery.

- Staff provided care with respect to patient's cultural and religious beliefs. This included enabling patients to retain religious clothing and providing privacy with their family, whilst maintaining clinical safety.
- Staff had access to Arabic lessons to help them communicate with patients. The lead physiotherapist was able to provide exercise classes in Arabic. There was also on-site translators available 24 hours a day, seven days a week.
- Dementia champions had been trained to provide targeted care to patients and their relatives. The hospital used the 'forget me not' symbol that discreetly enabled staff to identify when a patient was living with dementia.
- Staff worked together as a multidisciplinary team and with relatives to ensure international discharges were safe and well planned. For example, where patients needed to be discharged home to the Middle East, staff needed assurance that an appropriate social package of care would be in place for them. As the social care systems in this area did not operate similarly to the UK, staff worked to structure a plan for relatives to ensure patients would receive appropriate and safe support. An international liaison team worked with clinical staff to facilitate this.
- The on-site catering service provided patients with a wide range of options for meals, including diabetic, Halal and Kosher food. This service also catered for relatives and visitors and a team of catering hosts provided an individualised service to all people in the hospital. The team prepared fresh to-order meals that used seasonal, sustainable ingredients and could plan meals around nutritional needs and personal tastes. Staff we spoke with were positive about this service and said they felt the catering team "went out of their way" to meet individual needs. For example, the chef met with one patient to discuss their wishes for a specific type of food and was able to source this externally and prepare it on site.

- Printed information was available in the unit on key topics for patients and relatives, including infection control, patient-controlled analgesia and do not resuscitate procedures. A cartoon comic book was available for children of patients that specifically presented to critical care in a way to help them understand the environment.
- A dedicated waiting area for relatives was available on the ground floor of the building. Although this meant there was limited private space in the unit for relatives, we observed staff maintain a personal level of care to people. For example, one relative waited out of unit while their family member underwent observations. During this time a porter found the relative and offered them a hot drink and snack.

Learning from complaints and concerns

- The complaints policy was readily available on the unit and each member of staff had been trained to initially handle complaints, including minor concerns, before escalating them to a senior member of the team. This was provided in printed format on the unit and was also available on the provider's website.
- The hospital reported 99 complaints between October 2015 and September 2016 as part of its quarterly quality and safety monitoring. This was an overall figure for the hospital and is reflected in our overall report for this hospital. The critical care head of department investigated each complaint for the unit and shared learning with staff through team meetings. For example, one patient complained they found it difficult to communicate with some members of staff. As a result staff discussed their communication strategies and ensured patients had understood their instructions or information during each conversation.

Are critical care services well-led?

Outstanding



Leadership and culture of service

- A clinical critical care and acute services manager led care and governance in critical care services and were supported by a deputy chief nursing officer and chief nursing officer. A clinical critical care head of department was responsible for the daily operation of the unit.



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- All of the staff we spoke with described the senior team as visible and accessible. For example, RMOs said they had regular contact with the medical director who was also often on call. Staff described working relationships as positive and said the working culture was welcoming. For example, one member of staff said “I’m quite new here and I’ve been treated by respect by everyone. People take the time to explain things and have made me feel so comfortable and motivated.”
- Staff described the senior team as “very visible” and said heads of department and senior managers visited the unit daily. The critical care manager said this helped to keep their team motivated and engaged because they felt recognised.

Vision and strategy for this core service

- The hospital vision was, ‘exceptional people, exceptional care’. The strategy to deliver this involved anticipating patient and staff needs through the provision of efficient care pathways and a supportive and open environment. The hospital hoped that high quality care would lead to business growth.
- The critical care head of department led a five-part business plan for 2016 that included the introduction of new services, increasing collaboration with the international liaison team and increasing patient advocacy. Staff had made demonstrable progress with increasing follow-up with international patients and liaison with the international office to ensure discharge planning was safe and appropriate.
- All of the staff we spoke with had a passionate view of the provider’s ethos and business strategy and said they felt involved in the business plan for the future.

Governance, risk management and quality measurement

- Critical care services were included in the hospital’s overarching governance system. This was led by a senior management team. An ethics and compliance committee, medical advisory committee and governance committee met monthly and provided targeted governance oversight and reporting. The critical care lead consultant was the chair of the critical delivery group, which met quarterly as part of the service governance structure. This group also led the resuscitation working group. Nine governance committee sub-groups and six working groups were

responsible for specialist areas of safety, service and quality assurance. This included a clinical review group, risk review group and infection prevention and control practitioners working group.

- Governance and clinical teams used a risk register to identify and manage risks in each service, including critical care and the critical care manager maintained oversight of the risk register specific to the unit. At the time of our inspection there were three risks recently documented that applied to critical care, all of which had been resolved. For example, the unit had purchased a haemofiltration hoist to help staff move heavy consumables and avoid the risk of repetitive strain injury. The unit shared 13 risks with the hospital. All of the risks had controls in place and there was evidence of regular review, such as the monitoring of the quality of consultant-led patient reviews and the use of bank and agency staff. The critical care head of department led the management of risks in the unit and worked with colleagues in other departments to ensure solutions were applied in the best interests of each team and patient group.
- Where staff were accountable to different teams, there was a clear governance and leadership structure in place. For example, the housekeeper reported both to the critical care manager and the cleaning team manager. However, they had defined responsibilities and lines of support and supervision.
- Staff discussed the service risk register during team meetings and identified how they could contribute to the reduction or mitigation of risks, including through the use of standard operating procedures. We saw from looking at the minutes of meetings and the clinical quality dashboard that staff proactively worked to reduce the impact of risks when they were identified. For example, in July 2016 staff noted that lockable storage for patients’ own medicines was not available. In response a lockable cupboard was sourced.

Public and staff engagement

- Clinical staff were demonstrably passionate about the provider’s ethos and principles of care. However, some clinicians we spoke with said it was not always clear to them how to approach the ethics of medical care with the private model of treatment. This arose for example when a patient’s condition deteriorated and they spent longer in the hospital than originally planned and their family could not afford long-term care. This did not



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reflect a lack of support provided to them but they felt there could be more clarity about the balance between patient outcomes and the financial relationship with relatives.

- RMOs were dedicated to the critical care unit but maintained interests outside of the hospital as part of their roles and career plans. This meant they could not meet regularly as a whole team with the senior clinical team in the hospital. However, an RMO meeting had taken place two months prior to our inspection that involved both critical care RMOs and their hospital colleagues. The senior nursing team and medical director attended this and the team used it to review case studies, developments in the hospital and clinical issues.
- The relative of a patient who had died in the hospital and who had been living with Alzheimer's disease returned to deliver a training session to staff. This included how they felt about how they had been communicated with and highlighted the positive and negative aspects of this. Staff spoke positively about the opportunity to engage with this person and said it enabled them to communicate more confidently with patients and relatives.
- A profiling exercise had taken place with the staff team to identify their strengths, weaknesses, interests and passions. This resulted in new objectives set for each member of the team and helped to develop relationships between nurses and the senior team. The exercise also led to the introduction of quarterly critical care workshops that enabled staff to attend a multidisciplinary training day.

Innovation, improvement and sustainability

- The nurse manager had developed and successfully introduced the Belbin leadership style to the unit. This is a leadership strategy designed to build balanced, effective teams. The project enabled them to develop their leadership style and skills and support the team in building coherence and motivation. For example as a result of the leadership project the nurse manager had enabled staff to reconfigure their link or lead roles to match their abilities and interests. This meant one nurse took the lead on multidisciplinary liaison work and another organised case reviews of complex patients.
- A critical care delivery group enabled staff to focus on their professional and clinical development. This included establishing a five year plan that the provider supported them to achieve. For example, one nurse who had helped to implement the electronic patient records system had taken up a post in the IT department.
- The hospital supported staff to develop their own research in line with the values and plans of the unit. For example, the clinical lead was developing research to quantify the effectiveness of the follow-up programme for patients after they were discharged from the unit. Information from this could be used to improve the service and to identify earlier opportunities for intervention during inpatient spells.
- There was a demonstrable focus on sustainability in all staffing teams. This included training and development opportunities, flexible working and emotional support services. All of the staff we spoke with cited areas such as these as reasons they felt supported to stay in the hospital and develop. One member of staff said, "They [provider] have a track record of improving staff conditions and benefits to keep us here. It feels like they really want us to stay and they don't like letting us go."

Outpatients and diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Are outpatients and diagnostic imaging services safe?

Good 

Incidents

- There were no ‘never events’ reported for outpatients and diagnostic imaging between October 2015 and September 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- No serious incidents were reported involving the outpatients department (OPD) or diagnostic imaging between October 2015 and September 2016. The hospital incident log from the same time period showed the OPD and diagnostic imaging services had reported 25 non-clinical and 119 clinical incidents. The rate of clinical incidents in the outpatient department was higher than the rate of other similar independent acute hospitals. Staff told us there was an open culture for reporting and they felt confident to report.
- In the OPD for the period October 2016 to February 2017, 39 incidents were reported. 21 incidents related to paediatric patients; 16 paediatric patients waiting longer than 15 minutes to be seen by a consultant, 3 incidents when paediatric patients did not attend. There was no consistent theme with the other incidents that had been reported.
- Incidents were reported using the hospital electronic incident reporting system. The incident review group monitored and analysed incidents on a weekly basis for the whole hospital. Staff told us that they received feedback on the incidents they reported and on the trends within the hospital. Incidents were also discussed in the OPD’s monthly team meetings.
- The hospital had processes in place to report any radiation incidents to the Care Quality Commission (CQC) under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). One incident had been reported to the CQC in the reporting period.
- We saw incidents reported across the hospital were discussed in the monthly clinical governance committee meeting, and that action and learning points had been identified. In diagnostic imaging we saw that radiation incidents were reviewed and learning outcomes were discussed at the imaging radiation protection committee meeting. For the period January 2016 to November 2016 four incidents came under the radiation protection category. We saw how staff in diagnostic imaging had changed practice. They had introduced a ‘patient transfer’ form for ward staff to complete when accompanying in-patients to the department to ensure that the correct notes were brought with the patient to the department.
- From November 2014, NHS providers were required to comply with the duty of candour regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

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- Staff were aware of their responsibilities under the duty of candour, which ensured patients and/or their relatives were informed of incidents that affected their care and treatment and they were given an apology. There were no duty of candour incidents relating to OPD in the 12 months prior to inspection.

Cleanliness, infection control and hygiene

- The hospital reported no incidents of hospital-acquired MRSA between October 2015 and September 2016. MRSA is a bacterium that can be present on the skin and can cause serious infection. In the same period, there were also no cases of E. Coli or Meticillin Sensitive Staphylococcus Aureus (MSSA). MSSA is a type of bacterium that can live on the skin and develop into an infection, or even blood poisoning. There was one reported case of Clostridium difficile (C. diff) infection. C. diff is a bacterium that can infect the bowel and cause diarrhoea.
- On visual inspection, all areas we visited in the OPD and diagnostic imaging were clean and tidy. All the treatment rooms we visited were visibly clean. Rooms had daily cleaning schedules in place, which were up to date and signed.
- Treatment rooms had disposable curtains for privacy; these were dated to indicate when they next needed changing.
- We observed green 'I am clean' labels were in use to indicate when equipment was cleaned. For example, we saw green labels on treatment couches.
- We observed sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use.
- Cleaning equipment followed the National Reporting and Learning Service's (NRLS) national colour coding system for cleaning equipment, to ensure that equipment was not used in multiple areas, therefore reducing the risk of cross-infection.
- Adequate supplies of personal protective equipment (PPE) such as gloves and aprons were readily available in all clinical areas we visited. We observed all staff wore PPE where necessary. We noted all staff adhered to the 'bare below the elbows' protocol in clinical areas.
- Posters prompting appropriate hand washing technique in line with the 'five moments for hand hygiene' from the World Health Organisation (WHO) guidelines were clearly displayed and hand gel pumps were readily available in all areas. We observed staff demonstrated appropriate hand washing techniques. This reduced the risk of infections to staff and patients and was in line with good practice. Hand hygiene audits were undertaken quarterly and we looked at the hand hygiene audit undertaken in 2016. This showed 100% compliance with hand washing requirements in the diagnostic imaging and laser departments and 95% compliance in the OPD. An action plan was in place to address the areas of non-compliance within the OPD.
- The hospital had quarterly infection control committee meetings attended by senior management. There was a standard meeting agenda and we saw action points were identified and reviewed. For example as part of the audit programme for infection control actions plans were being reviewed by the infection control link practitioners.
- Infection control training formed part of the mandatory training programme for staff. The hospital target was for 85% of staff to have completed the training. Data provided by the hospital showed that 97% of all staff in the OPD and diagnostic imaging had completed infection control training.
- The hospital had a named infection prevention and control nurse. Each department had identified an infection control link practitioner who was responsible for undertaking the quarterly environmental and equipment audits.

Environment and equipment

- The hospital undertook quarterly environmental and equipment audits. The OPD was compliant in most areas in quarters one, two and three in 2016. However, the department scored 83% for public areas in quarters two and three, 80% for specimen transport in quarter two and 85% for staff and visitor's toilets in quarter three. This was below the hospital's target of 90%. An action plan was in place to address the areas of non-compliance which were being progressed.
- The consultation and treatment rooms were all well-equipped including with treatment couches and trollies for carrying the clinical equipment required.

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- There was resuscitation equipment available at each of the locations for OPD. We looked at the resuscitation trolley checklists and found staff had documented daily checks.
- There was adequate seating and space in OPD; however the hospital did not have dedicated waiting areas for children. Outpatient clinics were spread over three floors but could be accessed by stairs or a lift. The diagnostic imaging department was located on the ground floor.
- There was no bariatric equipment suitable for patients in the OPD or diagnostic imaging areas. Staff advised us that they were able to hire in equipment if required.
- The radiation protection committee meetings discussed equipment used by the diagnostic imaging and laser departments. We saw that action points were identified and monitored as part of the bi monthly meetings.
- The diagnostic imaging and laser department had arrangements in place to control and restrict access to the laser, X-ray and scanning areas including warning lights to indicate when the rooms were in use.
- Radiology staff had access to specialised personal protective aprons. These were available for use within all radiation areas.
- Health and safety training formed part of the mandatory training programme for staff. The hospital target was for 85% of staff to have completed the training. Data provided by the hospital showed that 93% of all staff in the OPD and diagnostic imaging had completed health and safety training.

Medicines

- There was a HCA Healthcare UK corporate medicines management policy in place, published in April 2016. The purpose of the policy was to make suitable arrangements for the recording, safe-keeping, handling and disposal of drugs.
- The pharmacy service was available Monday to Friday from 8.30am until 7pm. A duty manager facilitated access to medicines when the pharmacy department was closed. The pharmacy department was also open on Saturday mornings until 12.30pm.
- The medicines cupboards we inspected were locked and secure, all stock was within expiry date and there

was evidence of stock rotation. Cupboards containing substances hazardous to health were also locked. Only authorised staff had access to keys for the medicines cupboard.

- Diagnostic imaging kept their medicines in a locked cupboard and had a separate anaphylaxis drug kit to deal with life threatening allergic reactions requiring immediate treatment.
- There were no controlled drugs (CDs) kept or administered in the outpatient or diagnostic imaging departments.
- Fridge temperatures were checked and recorded daily and were within the required range to store medicines safely. Medicines management regulations stated minimum and maximum temperatures of locked medicine refrigerators and ambient room temperatures.
- In the OPD there was a safe and secure process in place for the management of prescription pads. We saw the pads were stored securely in locked cupboards and drawers and a system in place to record and log the usage of the prescription pads by specific clinicians. This meant there was information available to identify the serial numbers of the prescription sheet used, the patient prescribed to or the doctor prescribing.
- In radiology we found that prescription pads were only stored securely at night and there was no system in place to record or log the usage of prescription pads. This did not meet best practice guidelines for the use of controlled drug stationery.
- Staff were aware of the policies involving medicines management and knew where they were located in the department and on the staff intranet.
- Emergency drugs were kept on the resuscitation trollies in each area and staff documented daily checks.
- For our detailed findings on medicines please see the Safe section in the surgery report.

Records

- The OPD used both electronic and paper records. Nurses used an electronic record system and consultants used paper notes. Electronic records could

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only be accessed by authorised personnel. Computer access was password protected and staff used individual log-ins. Staff told us that paper records were scanned onto the system.

- We looked at three sets of electronic nursing notes and two sets of consultant's paper notes. On the electronic records we saw that these had been completed correctly. In the consultant notes we saw that there were copies of the patient's referral letter, correspondence, details of procedures/ consultation and histology report.
- The hospital told us that no patients had been seen without their medical records being available in the last three months. Staff told us records were always available for clinics.
- Consultants had to comply with data protection regulations and be registered as information protection officers if notes were to be taken off site. The hospital supplied security bags for records to be taken off site.
- Information governance training formed part of the mandatory training programme for staff. The hospital target was for 85% of staff to have completed the training. Data provided by the hospital showed that 100% of all staff in the OPD and diagnostic imaging had completed information governance training.

Safeguarding

- The hospital provided non-invasive OPD and diagnostic imaging to children under the age of 17 years. During the reporting October 2015 to September 2016 there were 440 out-patient attendances. The hospital employed a registered children's nurse (RNC) trained to safeguarding level four who would accompany children and their parents when on the hospital site.
- The hospital had a dedicated safeguarding lead for both adults and children and a named doctor for children. All staff we spoke with knew who the lead for safeguarding was.
- Staff were able to access the policies for both children and adults safeguarding policies via the hospital intranet. The safeguarding children policy was out of date and had been due for review in June 2016 we received a copy of the policy that was under review. The safeguarding adult's policy was up to date.

- All of the staff we spoke with demonstrated they understood safeguarding processes and how to raise an alert. They could access support from senior staff if needed. Staff were aware of their responsibilities to protect vulnerable adults and children.
- The hospital had an up-to-date chaperone policy. Staff were available for any patient requiring chaperoning. Notices were on display offering chaperones to patients in waiting areas in the OPD and diagnostic imaging department and corridors.
- Safeguarding adults and safeguarding children training formed part of the mandatory training programme for staff. The hospital target was for 85% of staff to have completed the training. Data provided by the hospital showed that 98.5% of all staff in the OPD and diagnostic imaging had completed safeguarding adults training levels one, two and three appropriate to their role, and 99.5% of all staff had completed safeguarding children level one, two and three appropriate to their role.

Mandatory training

- Mandatory training included basic life support, equality and diversity, ethics, fire safety, health and safety, infection control, information governance, manual handling, safeguarding adults and children.
- Mandatory training included e-learning and face to face meetings. Staff told us the quality of the training was good. We saw the hospital had a comprehensive training matrix in place to outline the type and frequency of the course staff were required to undertake.
- Training was monitored online and staff received reminders when a module was due for completion. Managers told us they regularly reviewed staff compliance with mandatory training. The hospital target was for 85% of staff to have completed mandatory training. Data provided by the hospital showed that 95% or more staff in the OPD and diagnostic imaging had completed seven of the ten modules and 94% of consultants with practicing privileges had completed mandatory training.

Assessing and responding to patient risk

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- If patients became unwell whilst in the OPD staff could escalate concerns about patients to their consultant, the RMO or the duty manager. The hospital also had an outreach team, made up of staff from critical care, available 24-hours a day.
- All clinic rooms and toilets had emergency alarm button and pull cords.
- If a patient required an emergency transfer to an appropriate NHS emergency department the hospital would use the 999 system to call an ambulance.
- The OPD had a procedure in place for admissions to the hospital from the OPD.
- There was currently one vacancy in the registered staff establishment at the time of the inspection here was a vacancy for a senior radiographer within the diagnostic imaging department which the hospital advised us they were actively recruiting to.
- Arrangements for handovers and shift changes in OPD and diagnostic imaging ensured patients were safe by ensuring enough staff were available at the right time.

Nursing staffing

- There were dedicated nursing staff across the OPD and radiographers within diagnostic imaging.
- The staffing in the OPD consisted of the Head of Department who was a registered nurse, 22 whole time equivalent (WTE) registered nurses and 3 WTE healthcare assistants. There was one vacancy in the registered staff establishment at the time of the inspection. HCA Healthcare bank staff were used to cover staff shortages in the department.
- The use of bank and agency nursing staff working in the outpatient departments was 22%. This was higher than the average for other independent acute hospitals in the reporting period October 2015 to September 2016. Senior managers told us the the OPD is fully staffed but had two vacant post which were covered by bank staff. This meant that the staffing levels could be adjusted dependent upon the patient lists Information provided by the hospital shows that in the three month period from July 2016 to September 2016 this was split between of 93% bank and 7% agency staff.
- The use of bank and agency staff working in the imaging departments averaged 8% for the 12 month period from January 2012 to December 2016.No bank or agency staff were utilised in August, October, November and December 2016.
- The staffing in diagnostic imaging consisted of 12 WTE radiographers. The department was led by a service manager and a deputy service manager with two superintendents, six senior radiographers, a sister, staff nurse and health care assistant.

Medical staffing

- Consultants who held clinics in the OPD and diagnostic imaging departments were responsible for the care of their patients. Secretaries organised the clinic lists around consultant and patient availability.
- There were 481 consultants recorded as having practicing privileges at the hospital. Of this number, 9% (41) worked regularly at the hospital undertaking 100 or more consultations from October 2015 to September 2016. A further 26% (125) consultants undertook between 10 and 99 consultations in the same time period.
- The chief executive officer (CEO) and the medical advisory committee (MAC) oversaw practising privileges for consultants. See Surgery and Medicine core service reports for detailed information.

Emergency awareness and training

- The hospital had an emergency preparedness, resilience and response (EPPR) policy and staff could access it on the intranet. This covered a number of incidents including major incident or emergency; chemical, biological, radiation, nuclear and explosive (CBRNE) incidents and infectious disease outbreak.
- Senior staff told us that they had an annual major incident desk top training.
- Staff told us there was regular testing of fire alarms and they knew where the fire assembly point was and how to evacuate patients and staff within their immediate areas
- Fire safety training formed part of the mandatory training programme for staff. The hospital target was for 85% of staff to have completed the training. Data provided by the hospital showed that 86% of all staff in the OPD and diagnostic imaging had completed fire safety training.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

Evidence-based care and treatment

- The hospital's policies used a combination of professional guidance produced by the National Institute for Health and Care Excellence (NICE), and Royal Colleges.
- Clinical policies and procedures were available on the hospital's intranet and staff were aware of how to access them.
- The senior team encouraged use of best practice guidelines. For example in the OPD an outpatient invasive procedure check list had been introduced which had been adapted from the World Health Organisation (WHO) safer surgery checklist. In the imaging department the WHO safer surgery check list had been adapted for radiological interventions and Breast interventions.
- At the time of our inspection the imaging department was working towards the Imaging Services Accreditation Scheme (ISAS) United Kingdom Accreditation Service (UKAS) Accreditation. The department was due to be inspected in May 2017.

Pain relief

- Pain relief medication was available on prescription from a consultant or Resident Medical Officer (RMO).
- Consultants discussed pain management in the consultation process for patients if required.
- The RMO was also available in the event of a patient requiring a review of their pain management.
- An on-site pharmacy service was provided for hospital inpatients and outpatients between 08.30 to 7pm Monday to Friday and from 9am to 12.30pm on a Saturday.

Nutrition and Hydration

- Water dispensers and tea and coffee machines were available for patients to use in the OPD waiting areas and in the diagnostic imaging department.

Patient outcomes

- The OPD and imaging departments undertook clinical and non-clinical audits. These included the national joint registry, infection prevention, hand hygiene, exception reporting, image quality, and OPD and to take out (TTO) turnaround times.
- We looked at the audit schedule, which covered audits such as resuscitation equipment, record keeping and medicines management.
- The imaging department used the PGMI tool to review the quality images. The PGMI (Perfect, Good, Moderate, Inadequate) method of evaluation of clinical image quality in mammography was developed by the United Kingdom Mammography Trainers Group with the support of the Royal College of Radiographers, aimed to ensure the maintenance of a high standard of mammography in breast screening and to facilitate a method of external audit.

Competent staff

- All nursing staff, radiologists and healthcare assistants had received an appraisal within the last 12 months and 94% of consultants with practicing privileges working in the OPD had an appraisal. The hospital had a practicing privileges policy in place and this set out that practicing privileges were to be reviewed annually.
- All new staff had completed an induction programme. New members of staff were required to complete mandatory training as part of their induction.
- The imaging department had a quarterly 'journal club' where the team would meet to discuss the latest new developments within their fields. This was introduced to ensure that practice was kept up to date.
- Staff told us that when a new service or equipment was introduced that the team were all sent on training and worked on another site where the equipment was operational for further training. For example when the hospital had a new CT scanners. Specialist support was also provided to ensure that staff were competent.
- Staff had training in dementia care and some of the staff we spoke with were dementia champions for the hospital. Although staff told us they did not see many patients with dementia, they found the training very helpful to understand the needs of those patients with dementia and their carers

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- We saw evidence that nurses, radiographers and others had appropriate skills, knowledge and experience to carry out their roles effectively. We looked at competency check lists and saw these were completed and signed.
- Staff told us that they were able to access further training. Staff gave us examples of further training that staff were able to access this included leadership training, magnetic resonance imaging (MRI) training and MRI two day course, and funding for a postgraduate course in imaging.
- Staff we spoke with told us and we saw that they had access to trust policies and procedures on the intranet. Staff were positive about the electronic access and felt they were always updated on relevant information via email and meetings.
- No patients were seen in the OPD without a paper or electronic record being available.
- Discharge summaries and discharge letter were sent to patients GP's with copies of the correspondence stored electronically.

Multidisciplinary working

- Many meetings were multidisciplinary (MDT) in the hospital. This allowed multi-disciplinary input from nursing, medical and diagnostic staff. There was evidence of collaboration across different services with OPD and diagnostic imaging. Staff told us consultants were approachable and always willing to give help and advice.
- There was a diagnostic MDT for breast patients to discuss patient after their breast diagnosis. This was attended by breast surgeon, radiologist, oncologist, breast care nurses, and radiographer. We saw that these meetings were minuted.
- We heard positive feedback from staff of all grades about the excellent teamwork.
- Consultants were able to take the original outpatients record of site. It is a requirement of the HCA practicing privileges policy that consultants are registered as a data controller with the Information Commissioner's Office (ICO) to gain practising privilege's at the hospital.
- Access to blood test results and imaging was provided electronically.
- The hospital used a radiology information system and picture archiving and communication system (PACS). This meant patients' radiological images and records were stored securely and access was password protected.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Seven Day Services

- The OPD and diagnostic imaging departments were open Monday to Friday from 8am to 8pm and on a Saturday from 8am until 1pm. The diagnostic imaging department also provided an out of hours on call service seven days per week.
- The inpatient and outpatient pharmacy service was available from 8.30am to 7pm Monday to Friday and from 9am to 12.30pm on a Saturday. An on call pharmacist was available out of hours for clinical advice. The duty manager and RMO have access to the pharmacy out of hours.

Access to information

- Staff told us that they had received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training. Staff we spoke with were aware of their responsibilities. The hospital had an up to policy for Deprivation of Liberty Safeguards.
- Staff told us that 16 years of age patients could consent to being seen on their own. An assessment would be undertaken by the RNC in conjunction with the consultant using the Fraser guidelines to assess a young person's competency to consent. These guidelines provided a legal framework for deciding whether a child or young person was mature enough to make decisions without parental consent.
- In five patient records we saw consent had been documented in records. However we did not directly observe consent being taken in outpatients. Staff told us that formal written consent was taken by the consultant involved when the patient was admitted for a procedure.

Outpatients and diagnostic imaging

- In the imaging department we saw verbal and/or written consent was documented as part of the WHO checklist for breast and imaging intervention.

Are outpatients and diagnostic imaging services caring?

Good 

Compassionate care

- Throughout the inspection we observed staff treat patients and visitors with compassion and care. Staff interactions with patients were courteous and professional. Throughout our visit we saw staff being helpful, stopping to speak to patients and showing them to where they wanted to go. This was supported fully by the patients we spoke with as they all expressed positive views about their experiences at the hospital.
- Patients told us they were happy with the care provided and that they were treated with dignity and respect. We observed staff being respectful at all times and with particular regard to patients' privacy and dignity.
- A patient who underwent minor surgery commented that the service they had received was efficient. Another patient told us they felt "like the Queen" and that they had been using the hospital for 12 years. Patients described the staff as "wonderful", "caring", "welcoming", and "polite". Patients felt staff knew what they are doing, and they felt safe and comfortable.
- The hospital undertook its own patient satisfaction survey, which was similar to the NHS Friend and Family test used to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. The results from the six month period from April 2016 to September 2016 showed that 99% of patients were extremely likely to recommend the service to others. The response rate was low at 15%.
- The diagnostic imaging department used their own satisfaction survey. The results showed a consistently high level of satisfaction with the service.

Understanding and involvement of patients and those close to them

- Patients we spoke with felt well informed about their care including any investigations that were planned. Patients said that consultants were thorough, took time to explain procedures to them and they felt comfortable and reassured. Patients felt they were given adequate information.
- Parents we spoke with were happy with the service their child received. Parents told us that the consultant spoke to their child and explained the treatment to them. One paediatric patient told us that they liked having their bloods taken by the RNC; we saw that they had been given stars which they stuck to their iPad.
- We spent time in the main outpatient reception area and observed patients being greeted and booked into the clinics. There were clear instructions for any paperwork that needed completing and patients were able to ask any questions.
- When patients were taken to the clinical rooms we observed that staff addressed each patient by name and escorted them to the appropriate place.
- The hospital's website provided information on the paying for treatment. Patients were able to pay for themselves. Treatment could also be funded through private medical insurance.

Emotional support

- We observed staff acting in a professional way. Patients told us staff were approachable and had time to explain things.
- Parents told us that the consultant was very supportive and that if they had any concerns they could contact them via email and that the consultant would come back to them straight away.
- Patients were given emotional support prior to entering the MRI machine. Patients were offered music, eye masks, blankets and a religious book to make them feel at ease. Staff told us that they had enough time to talk to patients for example patients who were claustrophobic so they could tailor their care. This procedure can often make patients feel nervous and the staff offered reassurance during the process.
- We saw relatives being invited to accompany patients into consultation rooms
- Chaperones were offered and available if required.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Good 

Service planning and delivery to meet the needs of local people

- The hospital offered a wide range of outpatient clinics and diagnostic imaging services to covering a range of specialities which included orthopaedics, dermatology, general medicine, ear nose and throat.
- Children were seen as outpatients with appointment to see consultants. The OPD and the diagnostic imaging department had a dedicated registered children's nurse (RNC) to support children under the age of 17 years when they attended consultations. Minor interventions such as wound care or phlebotomy services were provided by the RNC. Parents we spoke with were very positive about the service they received from the consultants and the nursing staff.
- Appointments could be coordinated between OPD and diagnostic imaging so that patients could be offered one stop clinics. Evening and Saturday appointments were also available.

Access and flow

- OPD staff did not audit referral to treatment times as there was no waiting list. Patients were offered the most convenient appointment with their preferred consultant.
- Patients were referred via their GP or they could book appointments on line or by booking directly with the consultant's secretaries. Patients we spoke with told us that had no problem arranging a suitable appointment
- We observed that patients were seen promptly and that patients were able to book the next available appointment with their chosen consultant. Staff told us that patients were seen promptly following referral and there were no waiting lists.
- The hospital audited waiting times in the OPD. The hospital standard was for patients to be seen within 15 minutes or less from the time of the scheduled

appointment, or arrival if the patient arrived after their appointment time. The audit undertaken in February 2017 showed that 91% of adult patients were seen within 15 minutes.

- The hospital also audited paediatric waiting times. Children were to be seen within 15 minutes of their appointment time or seen immediately after the previous appointment. For the period July 2016 to December 2016 showed an average of 94% of children were seen within 15 minutes or seen immediately after the previous appointment. An action plan had been put in place to reduce waiting times which had been completed.
- The hospital audited MRI waiting times in the imaging department. The hospitals standard was for all patients should be seen within 15 minutes of registration, and once registered, the patient should be called to MRI within 5 minutes. The audit undertaken in January 2017 showed that 33% (20/60) of patients were scanned within 15 minutes and 43% (26/60) of patients after 20 minutes of waiting time post registration.
- The hospital audited the CT referral to appointment and examination to report time. The audit undertaken in November 2016 showed 8/10 patients had their examination within 48 hours and 6/10 of patients were seen the same day or within 24 hours. For CT examinations, 9/10 were reported within 48 hours and 5/10 of examinations reported within 5 hours.

Meeting people's individual needs

- The imaging department had a discharge form for patients. If patients had an interventional procedure they were offered a follow up phone call. If the patient needed any aftercare they would be referred to the radiology nurse. This service was provided free of charge.
- Staff told us interpreting services could be booked for patients attending outpatient or diagnostic imaging appointments and that they could also use a dedicated language line service.
- The OPD and the diagnostic imaging department had staff identified as dementia champions. Patients with living with a learning disability or with dementia attending the OPD would be flagged by staff prior to their appointment and a plan formulated to support the

Outpatients and diagnostic imaging

patients whilst they were in the hospital. The staff we spoke with demonstrated a good understanding of the needs of patients with dementia. For example staff told us that they contacted family of an overseas patient who was living with dementia so they could complete the safety questionnaire for the patient who was due to have an MRI scan. We were assured patients who may be distressed or confused would be treated appropriately.

- The environment was appropriate and patient-centred with comfortable seating, refreshments and suitable toilets.
- The OPD did not have separate waiting areas for children. There were a few toys for children in the outpatient's waiting areas.
- Patients we spoke with were very positive about the outpatient and diagnostic imaging services and told us they received good treatment and were happy to attend these departments.
- Patients could have their bloods taken on the same day as the appointment and staff were trained to do this.
- Patients were able to access free Wi-Fi whilst in the hospital.
- Disabled patients could access and use the outpatient and diagnostic services. A lift was in use to access the various floors.
- A range of literature and health education leaflets were on display in the waiting areas.

Learning from complaints and concerns

- Information leaflets were available in all OPD the reception areas which provided details about the complaints process. The leaflets also had details of the independent sector complaints adjudication service. This information was also available on the hospital's website
- There was a system for capturing and learning from complaints. The hospital aimed to acknowledge all formal complaints within 48 hours with a target of 20 working days for a full response. The senior management team were informed about any complaints and changes were fed back through the heads of departments to frontline staff. Complaints were discussed at weekly senior management team meetings

and we looked at the minutes to confirm this. Once a complaint had been concluded a complaint summary and action plan was circulated to the relevant head of departments. Staff in the OPD told us that complaints were shared across the hospital for staff learning.

- The OPD had three complaints during the period October 2016 to February 2017. The one complaint was still being investigated. Senior staff described an open and honest culture and a willingness to accept responsibility for any shortcomings leading to complaints.
- Staff told us they tried to resolve complaints and concerns at the time where ever possible.

Are outpatients and diagnostic imaging services well-led?

Good 

Leadership and culture of service

- The chief nursing officer (CNO) was the overall lead for the OPD and imaging departments. The OPD lead nurse and diagnostic imaging service manager reported to the CNO. The heads of departments were responsible for the daily operation of their departments.
- Staff told us managers were supportive and approachable, they also felt they had opportunities for personal development and that when they raised concerns they were listened to and their concerns addressed. Staff told us they felt respected and valued.
- Staff were very proud to work for The Lister Hospital; they were enthusiastic about the care and services they provided for patients. They described the hospital as a good place to work. Some of the staff we spoke with had worked for the provider for many years and were enthusiastic about the services the clinic offered and the care that was provided.
- Staff we spoke with told us the senior staff were visible and that chief executive officer (CEO) knew staff names and took time to speak staff. One member of staff told us it was "nice to know that in such a massive organisation that you are so important".

Outpatients and diagnostic imaging

- Staff said there was an open and transparent culture where people were encouraged and felt comfortable about reporting incidents and where there was learning from mistakes.

Vision and strategy for this this core service

- The hospital had a clear vision and strategy which included the outpatient and diagnostic imaging departments. The hospital's vision was 'Exceptional people, Exceptional care'. All the staff we spoke with told us about the hospital's 'project world class' initiative and gave examples of how they incorporated this into their everyday practice. For example calling patients by their names, saying good morning and good afternoon, introducing themselves by name and role. Staff told us that it was about the personal touch and made them realise how important little things are.
- Senior staff told us that staff would go above and beyond to accommodate patients. For example, nursing and admin staff came in early to open the OPD at 7.30am for a patient who needed an early appointment.

Governance, risk management and quality measurement

- There was a clear clinical governance structure which included a range of meetings that met either monthly or quarterly. These included the clinical review group, risk review group, patient experience group, infection prevention and control group, and the quality improvement and patient safety group. Minutes of the clinical governance meetings demonstrated that incidents, complaints, and the risk register were discussed.
- The hospital had a risk register in place; this identified 13 risks across the hospital which was monitored with action plans in place. The register recorded the level of risk and the target level of risk. The risk register was updated on a regular basis and discussed at governance meetings. The OPD had a local risk register with two risks identified; these were patients who did not attend appointments, and the lack of separate waiting areas for paediatric and adults. These risks were not included on the hospital wide risk register. Staff we spoke with were aware of the risks in their area. The OPD also maintained an incident, complaints and risk register tracker.

- The service governance processes were the same throughout the hospital. We have reported about the governance processes under the surgery service within this report.

Public and staff engagement

- The imaging department undertook patient satisfaction surveys. Information provided by the hospital showed that during November and December 2016, 66 patients completed the survey which was a 100% response rate. The survey showed patients were 100% satisfied in their responses to ten out of the 16 questions, 90% or more satisfied in their responses to five out of the 16 questions. The department scored 89% being offered information explaining your examination.
- The hospital had recently established a patient's forum to gather feedback from patients.
- The OPD was planning to introduce electronic devices to capture feedback from patients which they could use to improve the services.
- The outpatient, imaging and cardiology heads of department said that they would always be seeking to develop and train their staff. They also worked with consultants on improving existing services and developing new services.
- The diagnostic imaging department had quarterly journal club meetings. This meeting was used to review new techniques and the latest technology update to improve their practice.
- Staff told us that the hospital had offered good benefits to staff to encourage them to stay. These included health insurance, cycle to work schemes, dental and critical illness cover. Family members could also benefit. Staff were also able to buy back annual leave.
- Staff told us that their departments had regular activities and there was a strong social side to the hospital. This included an annual picnic in the park and Christmas dinner for all the staff served by members of the senior staff team.
- The hospital public and staff engagement processes have been reported on under the surgery service within this report.

Innovation, improvement and sustainability

Outpatients and diagnostic imaging

- The diagnostic imaging department was due to be inspected in May 2017 so that the department could be accredited under the Imaging Services Accreditation Scheme (ISAS) United Kingdom Accreditation Service (UKAS) Accreditation.

Outstanding practice and areas for improvement

Outstanding practice

- We found that staff went above and beyond their duty to accommodate patients' individual and differing needs in different ways.
- We found that staff maintained a culture of friendly professionalism, support and respect for each other at all levels throughout the surgical and medical division.
- In critical care, staff demonstrated a consistent approach to providing highly individualised care that contributed to emotional wellbeing and a positive recovery. This included facilitating family visits at mealtimes, and learning Arabic to communicate effectively with patients and their families. Individual examples included ordering fresh flowers to decorate a patient's hair ready for discharge, and inviting a relative to eat lunch with staff each week.
- A consultant intensivist led a critical care post-discharge support programme (PDSP), that was based on a holistic model of care. This meant the service provided support for improved physical health and wellbeing, as well as for psychological health. The PDSP had an international scope. Patients who were discharged to countries outside of the UK had access to this by video link.

Areas for improvement

Action the provider SHOULD take to improve

Surgery

- The hospital should ensure that all staff have access to the same system for documentation to increase consistency and continuity of records and care.
- The hospital should investigate and address vacancy rates for inpatient and theatre staff and turnover rates of inpatient nurses.
- The hospital should ensure that consultants' documentation is complete.
- The hospital should ensure all controlled drugs related errors continue to be managed correctly.

Outstanding practice and areas for improvement

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- The hospital should ensure prescription pads are stored securely and there is a system in place to log the usage of prescription pads.
- The hospital should ensure that the children's safeguarding policy is reviewed.

Medicine

- The hospital should ensure that the quality of documentation of consultants is monitored and any issues are addressed.
- The hospital should ensure that all staff have access to the same system for documentation to increase consistency and continuity of records and care.
- The hospital should ensure that all staff complete their mandatory training, ensuring that the hospital target of 85% is exceeded.
- The hospital should consider the addition of a multi-faith room for staff and patient use.
- The hospital should ensure that all complaints are responded to within the 20 day timeframe.