

# New Hall Hospital

## Quality Report

Bodenham

Salisbury

SP5 4EY

Tel: 01722 422333

Website: [www.newhallhospital.co.uk](http://www.newhallhospital.co.uk)

Date of inspection visit: 10 to 11 April 2018

Date of publication: 26/07/2018

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

Are services safe?

Are services well-led?

### Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

# Summary of findings

## Letter from the Chief Inspector of Hospitals

New Hall Hospital is operated by Ramsay Healthcare UK. The hospital has 33 beds which consist of single en-suite rooms, along with two and four bedded bays. They also have eight pods (small single-occupancy rooms) used by patients having day case procedures. The service was due to open an ambulatory care unit for patients undergoing minor procedures. At the time of our inspection this was near completion and due to open within the next few months.

Facilities include four operating theatres including a dedicated spinal theatre, and outpatient and diagnostic facilities including a CT and MRI scanner. Chemotherapy services are provided to a small number of patients and they provide a physiotherapy service.

The hospital mainly provides surgical services, and outpatients and diagnostic imaging for adult patients. They do not treat children.

The hospital was inspected in August 2016 and they received a rating of good. We carried out a focused inspection of the surgical services on the 10 and 11 April 2018 in response to some concerns arising from intelligence received and the routine monitoring of services. We looked at only two key questions. Are services safe? Are they well led? We did not inspect outpatient and diagnostic services.

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.

### Services we rate

We found the following areas of good practice:

- There was a strong, supportive and enthusiastic leadership team at the hospital which was focused on maintaining a safe facility, with good quality outcomes.
- The hospital was well-equipped and had the necessary facilities to provide a wide range of treatments in a way that met the varying needs of patients. Facilities were specifically designed to manage in-patient, day case and minor procedures safely and efficiently.
- There were opportunities for training and career development within the organisation and staff were given encouragement to learn.
- The hospital had effective systems and controls to minimise the risk of infections. The working environment was visibly clean. We saw good microbial stewardship and regular audits ensured infection control standards were maintained.
- Medicines were managed safely and securely and audited regularly to ensure policies and procedures were being followed. Information about medicine was provided to patients on discharge to ensure they used the medicine effectively and understood any side effects.
- Pathways were used effectively to ensure patients at risk were managed appropriately and safely. Medical attention was available when it was needed. Protocols for managing unexpected complications or emergencies were available and arrangements were made to transfer patients if necessary.
- Incidents were investigated and there was a strong learning culture which ensured the hospital learned from adverse events and made improvements to ensure they did not happen again.
- There was a clear vision and strategy for the hospital which was ambitious, linked to the needs of the local population and focused on quality and sustainability.

# Summary of findings

- The hospital had a respectful and enthusiastic working environment and staff in all roles had a compassionate and patient-focused approach to their work. There were healthy positive relationships between staff and managers where ideas were encouraged and people were not afraid to challenge.
- Governance arrangements at the hospital were effective and risks were well-managed. There was a committee structure which provided good oversight. Committees linked up to provide a strong framework where finances, clinical performance and quality outcomes could be monitored and improved.
- The hospital collaborated with a wide network of stakeholders, including local trusts, commissioners, clinical networks and the local authority. This ensured their practices were up to date and in line with contractual requirements and best practice.

We found the following areas of practice that require improvement:

- Some staff were not up to date with their mandatory training, in particular safeguarding level 2, data protection and emergency management of patients.
- Intra-operative temperature monitoring for patients undergoing surgery was not in line with national best practice guidance.
- Carpets were used in the patient rooms which made it difficult to keep floors clean.
- Staff morale in radiology was lower than rest of the staff group and some staff said they felt overwhelmed with work due to staff shortages.
- Some staff wore long-sleeved jackets in clinical areas which presented a risk of cross contamination.
- We were not assured that risks relating to areas overseen centrally by the provider's corporate group were being actively managed.
- There was a lack of storage space which meant the working environment was cluttered in theatres and in the administrative areas.
- Tourniquets used in upper-arm surgery were not used in accordance with manufacturer's guidance. This presented a risk of tourniquet-related complications.
- The dispensing of medicines when the pharmacy was closed was not in line with the organisational medicines policy and we were not assured that practices around take-home medicines were compliant with best practice.

Following this inspection, we told the provider that it 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.

**Amanda Stanford**

**Deputy Chief Inspector of Hospitals (South), on behalf of the Chief inspector of Hospitals**

# Summary of findings

## Contents

<b>Summary of this inspection</b>	Page
Background to New Hall Hospital	6
Our inspection team	6
How we carried out this inspection	6
Information about New Hall Hospital	7
The five questions we ask about services and what we found	8
<hr/>	
<b>Detailed findings from this inspection</b>	
Overview of ratings	11
Outstanding practice	24
Areas for improvement	24

---

# New Hall Hospital

**Services we looked at:**

Surgery

# Summary of this inspection

## Background to New Hall Hospital

New Hall Hospital is operated by Ramsay Healthcare UK. The hospital opened in 1980 and is located in a Georgian Manor House near Salisbury, Wiltshire. The hospital primarily serves the communities of Wiltshire, Hampshire and Dorset. It provides NHS surgery to patients from six Clinical Commissioning Groups and specialises in spinal surgery. Approximately 81% of the hospital's business comes from NHS patients.

The hospital has 33 beds and four operating theatres. A new suite specialising in minor procedures was near completion and due to open soon after our inspection. There are also nine consulting rooms, a minor treatment room, a physiotherapy suite and radiology facilities. The hospital also provides a range of surgical services including orthopaedic and general surgery, ophthalmology, urology, gynaecology, cosmetic, maxilla-facial, and dermatology.

The hospital's registered manager has been in post for approximately two years. Clinical services are led by a matron and five managers in the ward, theatres, outpatients, radiology and physiotherapy. The matron is also the controlled drug accountable officer. The outpatient manager is also the hospital's quality improvement lead.

The hospital is registered to provide the following services:

- Diagnostic and screening procedures
- Family Planning
- Surgical Procedures
- Treatment of disease, disorder or injury

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and two specialist advisors with expertise in theatres and governance. The inspection team was overseen by Julie Foster, Inspection Manager.

## How we carried out this inspection

We last conducted a comprehensive inspection at this hospital in August 2016 when we inspected surgery, outpatients and diagnostic imaging. The hospital received an overall rating of good. At that time we looked at five key questions and gave them a rating of good for all questions:

- Are they Safe?
- Are they Effective?
- Are they Caring?

- Are they Responsive?
- Are they Well led?

We re-visited the hospital and carried out an unannounced focused inspection on 10 and 11 April 2018 when we looked at surgical services. We conducted this inspection to follow up on some new concerns which had been identified through our routine monitoring activity. We focused our inspection on whether surgical services were safe and whether they were well-led.

# Summary of this inspection

## Information about New Hall Hospital

New Hall Hospital is operated by Ramsay Health Care UK. The hospital has 33 in-patient beds configured in a range of single and double rooms and four-bedded bays. The hospital is located in Bodenham, a rural location near Salisbury, Wiltshire.

During the 12 months prior to this inspection, 8,915 operations were undertaken at the hospital and approximately 81.6% of the hospital's business came from NHS patients. The remaining patients were privately insured and self-funding patients. The hospital is a significant provider of spinal surgery in the south west region. The most common procedures were caudal epidurals (injection of steroids into the back) (609) and nerve root injections (607) for spinal patients and knee arthroscopies (exploration of the knee joint) (257).

In total, 104 consultant surgeons worked at the hospital under a practising privileges arrangement and a further three surgeon were directly employed. Anaesthetic services were provided by an anaesthetic group from a local trust. The hospital also employed one pharmacy assistant, four radiographers, seven physiotherapists, 60 nursing staff and 34 health care assistants, four sterile services technicians and five operating department practitioners. There were also a range of managerial and administrative staff and those working in support services, such as catering, portering, housekeeping and maintenance.

During the inspection we spoke with 26 members of staff including: registered nurses, health care assistants, operating department practitioners, pharmacy staff, department managers, administrative staff, medical staff, operating department practitioners, and senior managers. We also conducted a drop-in session where staff could share their experience of working at the hospital; this was well attended by staff across the hospital. We also reviewed five sets of patient records and observed 12 episodes of patient care.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital was last inspected in August 2016 when it received an overall rating of good, which meant that the hospital was meeting all standards of quality and safety it was inspected against.

Track record on safety

- One never event (downgraded after investigation)
- 31 clinical incidents, of which 21 were categorised as no harm, 12 low harm, two moderate harm and zero severe harm or death
- zero serious injuries
- zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli

There had been:

- one significant complaint
- 39 low level complaints

### Services accredited by a national body:

- Joint Advisory Group (JAG) Accreditation for Sterile Services Department
- Joint Advisory Group on GI endoscopy (JAG) accreditation, last accredited in 2017

### Services provided at the hospital under service level agreement:

- Mobile imaging and treatment (radiology) services
- Anaesthetic services
- Pathology and histopathology services
- Provision of blood components
- Critical care transfers
- Pharmacy services
- Hydrotherapy

# 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:

- The hospital was well-equipped and had the necessary facilities to provide a wide range of treatments in a way that met the varying needs of the patients. Facilities were specifically designed to manage in-patient, day case and minor procedures safely and efficiently.
- There were opportunities for training and career development within the organisation through the Ramsay Academy. Staff were given encouragement and opportunities to learn.
- The hospital had effective systems and controls to minimise the risk of infections. We saw good infection control practices, good microbial stewardship and regular audits ensured that high standards were maintained.
- Medicines were managed safely and securely and audited regularly to ensure that policies and procedures were being followed.
- Patients were provided with helpful information about their surgery and medicine to ensure that they understood how to manage their wound, what side effects to expect and know when they should seek help.
- Pathways were used effectively to ensure patients at risk were managed appropriately and safely. Medical attention was available when it was needed, protocols for managing unexpected complications or emergencies were available, and arrangements could be made to transfer patients if necessary.
- Incidents were investigated and there was a strong learning culture which ensured the hospital learned from adverse events and made improvements to ensure that they did not happen again.

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

- Some staff were not up to date with mandatory training and compliance was particularly low for Safeguarding level 2, Data Protection and Emergency Management of Patients.
- Patients did not have their intra-operative temperatures monitored during surgery in line with national best practice guidance. This is needed to prevent hypothermia and related surgical complications such as infection.

# Summary of this inspection

- Carpets were used in some patient rooms which made it more difficult to keep floors clean. This is not in line with best practice guidance.
- Some staff were not compliant with the uniform policy and were not bare below the elbow in clinical areas. Long-sleeved jackets were worn in the clinical area. This presented a risk of cross-contamination.
- There was insufficient storage in theatres and in some administration areas which led to a cluttered and unsafe working environment.
- Staff did not use six-use tourniquets in accordance with manufacturer's instructions and did not record the time in which the tourniquet had been applied. This increased the risk of tourniquet injuries.
- Medicine reconciliation checks at the weekend did not always happen within the 24 hour standard set by the organisation.
- The dispensing of medicines by nurses when the pharmacy was closed was not in line with the organisational medicines policy.
- We were not assured that practices around take-home medicines were compliant with best practice.

## Are services well-led?

We rated well-led as good because:

- There was a strong, supportive and enthusiastic leadership team at the hospital, focused on maintaining a safe facility with good quality outcomes.
- There was a clear vision and strategy for the hospital which was ambitious, linked to the needs of the local population and focused on quality and sustainability.
- The hospital was a respectful and enthusiastic working environment and staff in all roles had a compassionate and patient-focused approach to their work. There were healthy positive relationships between staff and managers where ideas were encouraged and people were not afraid to challenge.
- Governance arrangements at the hospital were effective and risks were well-managed. There was a committee structure which provided good oversight. They linked up to provide a strong framework where finances, clinical performance and quality outcomes could be monitored and improved.
- The hospital collaborated with a wide network of stakeholders, including local trusts, commissioners, clinical networks and the local authority. This ensured their practices were up to date and in line with contractual requirements and best practice.

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

# Summary of this inspection

- There was a risk on the risk register belonging to the corporate team but there was no record of any steps taken to control or mitigate the risk.
- Morale was low in the radiology team and staff felt overwhelmed due to staff shortages.

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	N/A	N/A	N/A	Good	Good
Overall	N/A	N/A	N/A	N/A	N/A	N/A

# Surgery

Safe Good 

Well-led Good 

## Are surgery services safe?

Good 

We rated safe as **good**.

### Mandatory training

- The hospital used a mandatory training matrix to show what training was required for each job role and the expected frequency of the training. Training was delivered through a combination of e-learning and face to face. Staff found they could usually find the time in their working day to complete the required training. Training was provided in non-clinical subjects such as manual handling and fire safety and clinical subjects such as advanced life support, intravenous drug administration and blood transfusion skills. New staff were able to access the e-learning modules prior to the start of their employment and were encouraged to complete as much as possible before they started.
- The hospital were unable to give an up to date picture of mandatory training compliance during the inspection, as there was a temporary problem with the on-line system used. Data provided after the inspection reported they were just below where they expected themselves to be for compliance with mandatory training at 82%. The hospital's target for mandatory training compliance was 85%. However, when comparing the number of individual training courses completed against the number expected, the compliance total was 79%.
- Compliance reports were provided to several internal governance meetings to make managers aware when staff were out of date with mandatory training. Records provided showed over 85% compliance in a number of subjects including safeguarding level 3, manual handling, equality and diversity and health and safety. The subjects with the lowest compliance were data protection (57%), safeguarding adults level 2 (57%) and emergency management (67%).

- Staff had access to an on-line training system which recorded the training they had completed and told them when re-training was due. During the inspection, there were some technical issues with the system which meant some training had been completed but the on-line system had not been updated. We saw training sessions being offered regularly to staff.
- Requirements for resuscitation training varied depending on each staff member's job role. All ward and theatre staff received training in intermediate or advanced life support. Basic life support training and familiarisation with automatic defibrillators was available to non-clinical staff who wished to undertake it.
- In addition to mandatory training, new staff were provided with a practical skills competency booklet which recorded their attainment of the practical skills required for their role. Example of such skills for a healthcare assistant included, training in assessing and recording a pulse and respiratory rate, and how to check and aspirate a nasogastric tube. Additional courses were also available through the Ramsay Academy and through the Royal College of Nursing. These were e-mailed to staff by the lead nurse for training.

### Safeguarding

- The hospital had comprehensive policies and processes for the safeguarding of adults and children that reflected current safeguarding legislation and protected vulnerable adults and children from neglect or abuse.
- Training relating to safeguarding adults and children was included in the organisation's mandatory training plan. At the time of the inspection this training included the subjects of forced marriage and female genital mutilation. The training did not yet include the subject of modern day slavery but we were told this was planned during the coming year when the hospital was due to switch to a new e-learning learning programme.
- There were designated lead nurses for adult safeguarding, child safeguarding and for 'Prevent'. Prevent is a national programme to reduce the risk of

# Surgery

people becoming terrorists or supporting terrorism. The hospital did not treat children; however, staff recognised their duties in relation to the safeguarding of children who may visit the hospital and those of patients.

- We saw safeguarding display boards on the wards, outpatient and administration areas with relevant pathways and information about safeguarding. There was also a national safeguarding lead who took overall responsibility for the hospital's safeguarding policies.
- Staff had an awareness of adult and child safeguarding, understood where to get advice and knew how they would report a concern. Safeguarding concerns were reported initially to a lead nurse and then to the local authority via their telephone helplines. Relevant contact numbers were on the safeguarding display boards.
- There was a chaperoning policy and signs on display to advise patients of the availability of chaperones. Following a recent incident, a new process had been introduced which required patients to confirm whether they would like a chaperone during their examination and to give consultants the right to insist a chaperone was present when they felt it necessary. We were told by the outpatient manager that the patients had responded positively to this new procedure.

## Cleanliness, infection control and hygiene

- There were effective and comprehensive systems to minimise the risk of infection. Staff were appropriately trained, hygiene practices were monitored and incidents of infection were analysed to identify opportunities for improvement. There was a lead nurse for infection control who had a good understanding of the potential risks in the hospital and was pro-active in finding ways to reduce risks of infection. A quarterly report was produced which detailed infection control audit, monitoring and improvement activity which was shared in quarterly infection control committee meetings.
- Staff were trained in infection control procedures during induction and through mandatory training. Staff were asked to demonstrate appropriate cleaning and infection control practices when completing role-specific tasks. This was documented in the practical skills competency workbooks.

- During the inspection we visited wards, theatres, radiology, pharmacy and administrative areas which were all visibly clean. Staff used 'I am clean' stickers on equipment so they could quickly tell if equipment was clean and ready to use.
- Cleaning rosters were displayed and daily signing sheets had been completed with very few omissions. Theatres were deep cleaned every six months and had last been deep cleaned in March 2017. There were air ventilation systems in theatres to reduce the risk of airborne contaminants, including three laminar flow and one clean air filter. Legionella checks on the water supply were completed bi-monthly.
- The Patient Led Assessment of the Care Environment (PLACE) scored by the hospital for cleanliness was 99.16% for the year 2017. PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). This score was an improvement on the previous year's score of 97.81% and was above the national average.
- Clinical staff were mostly bare below the elbow, demonstrated good handwashing and used sanitising hand gel when appropriate. We saw occasional non-adherence to uniform policy from portering staff who were wearing long-sleeved jackets in clinical areas. The same jackets were then worn when moving patients around the hospital. This was not in line with infection control policy or good practice. The hospital's policy was that long sleeved jackets should be worn over scrubs when outside the theatre department, but in the clinical areas they should be bare below the elbow.
- Surgical staff followed hospital policy when preparing for invasive surgery. Hands and lower arms were cleaned and all scrubbed staff were wearing sterilised gowns and gloves before having contact with the patient. We observed appropriate use of personal protective equipment (PPE) around the hospital, including gloves and aprons, and this included when disposing of clinical waste. We saw barrier nursing implemented when appropriate to minimise the spread of infection. Regional decontamination hubs were available to clean equipment if necessary.

# Surgery

- Clinical and sharps waste was disposed of safely. Waste was segregated with appropriate bags were used to collect waste and disposed of in line with national guidance. Sharps bins were dated and signed at the commencement of use and were not over-filled.
- Patients were appropriately prepared for surgery and were given information on discharge about how to look after their wounds to minimise the risk of infection. The infection control lead nurse was exploring new ways of managing wounds through negative pressure dressings. Any wound infections were reported on the adverse incident reporting system.
- The infection control lead nurse was aware of the risk of infection from catheters and told us she was working with colleagues to minimise the length of time urinary catheters remained in situ following surgery.
- The decontamination of endoscopes took place at the hospital and the facility was accredited by the Joint Advisory Group for gastrointestinal endoscopy (JAG). We inspected the Central Sterile Services Department (CSSD) and the processes used were in accordance with the Health Technical Memorandum on decontamination. Scopes were decontaminated after each use.
- Comprehensive audit systems enabled compliance with infection control procedures to be monitored. The infection control lead nurse audited all incidents of infections to look for themes and clusters. The data was shared and discussed at the infection control committee.

## Environment and equipment

- The design of the premises and facilities was suitable for its intended purpose which meant patients could receive safe care. The hospital had recently expanded to offer additional services such as an ambulatory care suite. This was designed in a way which met patient requirements and also met best practice guidance, for example the flooring and hand wash basins met the required standards and chairs could fully recline in case a patient became unwell. There was also sufficient space to bring in additional equipment if it was needed in an emergency.
- In some of the patient rooms where carpet tiles were used, which made them difficult to clean. Staff were able to describe how the carpet tiles were cleaned and decontaminated. We were told that the tiles could be replaced if contaminated and they were cleaned weekly and steam cleaned in-between if necessary. Best practice guidance from the Department of Health (Health Building Note 00-09) suggests flooring should be seamless and smooth, slip-resistant, easily cleaned and appropriately wear-resistant. The carpeted rooms were on the hospital risk register and all rooms recently refurbished had smooth flooring.
- There were arrangements for the repair and maintenance of the facilities. During the inspection we saw premises which were clean and in a good state of repair and they were light and spacious. In multi-occupancy rooms curtains were available to ensure privacy during examinations. However, it was possible that private or sensitive conversations could be overheard, especially in the smaller double rooms.
- We found there was limited space for storage in some areas. In one of the theatres, equipment had been stored around the sides of the theatre. This had made it difficult for staff to move around, especially as the staff tended to lay up their equipment in the theatre as the preparation area was felt to be too small. We were also told there was insufficient storage space for some of the administrative staff who found their working environment to be cramped and cluttered.
- Equipment was serviced and maintained by an external contractor. Staff told us equipment repairs were carried out quickly and there was sometimes same-day service. Staff said cancellations due to unavailability of equipment were rare. During the inspection, there was a problem with the autoclave (used to sterilise equipment), but managers had a contingency plan to use one at a nearby acute hospital.
- The hospital's accreditation for JAG (Joint Advisory Group on GI Endoscopy) was renewed in February 2018. The JAG accreditation scheme is where endoscopy services are independently assessed against a set of recognised standards to give assurance the service is of a high standard.
- There were designated radiation protection advisors to ensure the MRI and scanning equipment and environment met the ionising radiation medical exposure regulations (2017). The risks associated with working with radiation and magnetic field injury were listed on the risk register and reviewed yearly. Radiation protection was discussed at the quarterly health and safety committee meetings.

# Surgery

- Single use equipment was used when available which minimised the risk of cross contamination. All consumables seen were in-date, in good supply, checked regularly and accessible in emergencies.
- The exception to this was the use of tourniquets (bands used to constrict blood flow to a limb) during arm surgery. We noted the tourniquet was designed to be used six times before being discarded. Notches should be applied to the tourniquet each time so that staff could see how many times it had been used. Staff were not using the notches and so could not tell how many times the tourniquet had been used. We asked staff about this and were told they were waiting for single-use tourniquets to arrive. We also found the time at which the tourniquet was applied was not displayed in theatre. Prolonged use of tourniquets or using excessive or insufficient pressure can increase the risk of tourniquet-related complications. Tourniquet time should therefore be monitored and they should be used in accordance with manufacturer's instructions.

## Assessing and responding to patient risk

- Risks to patient safety were minimised by using the 'five steps to safer surgery'. This was a World Health Organisation surgical safety checklist which encouraged team work and communication within the surgical team to reduce errors. We observed staff using the checklist effectively. We also saw good briefing and de-briefing and use of the surgical pause to ensure everyone was ready before the first incision. An observational audit including five separate observations of the WHO checklist had been completed, however it appeared this had been done just once since the start of the audit year in July 2017. It had not been repeated because the audit showed 95% compliance. This was in line with the Ramsay audit policy.
- Leaflets were given to patients with advice about how to look after their wound, what post-operative symptoms they should expect when they should seek urgent medical attention. Phone numbers were provided so patients could call for advice after discharge. For such post-discharge enquiries, questionnaires were used so staff taking the calls could capture the relevant information and decisions could be recorded.
- Staff were provided with aide-memoires so they could quickly review important pathways, such as the sepsis screening tool and how to make an SBAR call (Situation, Background, Assessment, Recommendation - a rapid mnemonic for handing over vital patient information to a receiving clinician or hospital).
- The hospital was working closely with a local acute trust to develop joint pathways to identify patients with acute kidney injury (AKI) and to ensure their treatment was appropriate. They were introducing a stamp to mark the drug charts of patients with AKI to ensure the condition was not overlooked when prescribing medicines and developing a new pathway for managing AKI patients.
- The hospital was using monitoring tools and specific pathways and tools for managing deteriorating patients. These included the use of the National Early Warning Score and specific tools for the identification of urinary tract infection and sepsis screening. There were protocols on display in theatres for rapid transfusion of fluids in response to major haemorrhage. There was comprehensive guidance for assessing the risks of venous thromboembolism (VTE), including guidance on prophylaxis and a risk assessment tool. The hospital also had policies relating to palliative care, end of life and advanced directives.
- The hospital used a separate assessment record for acutely unwell patients who required transfer. This ensured essential clinical information was clear and accessible.
- All patients who had a diagnosis of dementia were identified on admission and a pathway existed to ensure the needs of the patient were properly understood. This ensured they remained safe during their stay and discharge.
- Patient temperature monitoring during surgery was not consistently monitored to identify hypothermia in line with NICE (National Institute of Health and Care Excellence) Guideline CG65. We observed a procedure which exceeded 30 minutes where no peri-operative patient temperatures were recorded during surgery. We also reviewed two further sets of patient notes and saw that no temperatures had been recorded. Hypothermia in patients during surgery puts them at risk of complications including bleeding and infection. NICE guidance recommends patient temperature to be recorded before the administration of anaesthetic and every 30 minutes during surgery. The infection control lead nurse had already identified compliance with temperature recording during audits. Some patients who had developed post-operative infections had been

# Surgery

found not to have had their peri-operative temperatures recorded. There had been discussion about this risk at an infection control committee meeting in September 2017. It was proposed the issue would be addressed within a wider improvement project but no specific action had been recorded. It was not reviewed at the next meeting in January 2018. We asked the infection control lead nurse about plans to address this risk and we were advised that evidence was being collected to support an improvement plan.

- Resuscitation trolleys were accessible and well-equipped. The hospital had introduced the practice of always having a staff member trained in adult life support in theatre, in addition to the surgeon and anaesthetist. All other clinical staff had training in intermediate life support.
- Nurse-led preadmission checks were completed to minimise likelihood of complications during surgery as there were no high dependency beds at the hospital. Criteria had been applied to ensure that patients at higher risk of complications received their care at an alternative hospital with appropriate facilities. A service level agreement was in place to support such transfers.

## Nursing and support staffing

- The hospital was staffed with sufficient nurses, operating department practitioners and health care assistants to keep patients safe and address their needs. During the inspection staff told us they were able to manage the tasks expected of them. Staffing and skill mix was determined using an organisational acuity tool and managers were also allowed to use their discretion and have additional staff if they felt it was needed due to the needs of patients. The exception to this was radiology where two full time equivalent staff vacancies existed. Radiographers told us, they felt overwhelmed and were unable to work safely and effectively due to a shortage of radiology staff. They said their concerns had been raised with senior management and recruitment was underway.
- Agency usage was low and had reduced in months prior to the inspection due to a recruitment drive in October 2017, when 15 new employees had been recruited. In the twelve months prior to the inspection, the percentage of shifts filled by agency staff were 6% on the ward, 7.5% in theatres and 0.2% in day surgery unit.

- We observed a staff changeover on the ward and saw that handovers were handled in a safe way. Staff on the ward was given appropriate time to review the care needs of the patient and communicate these clearly.
- The hospital offered places to student nurses and ran an apprenticeship programmes for business and administration roles. The students we spoke to on the ward said they were well-supported. Ramsay referred to 'growing their own' talent through the Ramsay Academy. They had acknowledged the shortage of qualified healthcare staff, and had endeavoured to address this by offering internal training and career development pathways.

## Medical and surgical staffing

- Arrangements for surgical and medical staffing ensured clinical emergencies could be effectively managed and patients were kept safe. There were 104 surgeons who held practising privileges at the hospital. The hospital also directly employed a further three surgeons.
- There was a resident medical officer (RMO) at the hospital at all times responding to the everyday needs of the patients. Senior support was available when it was needed from the patient's own consultant or an on-call surgical consultant. The RMO was provided by an agency and worked seven days at a time. There were arrangements for monitoring the working hours. Contingency plans existed if the RMO worked long hours in the night, the agency would send another RMO to the hospital to allow appropriate rest.
- Records were maintained confirming revalidation dates for surgeons working at the hospital. Most surgeons' appraisal arrangements were managed by their main employer and arrangements were in place to provide appraisals for those directly employed. The registered manager had recently written to them advising that their appraisal must be up to date or their practising privileges would be suspended. At the last inspection it was identified the hospital could not evidence that the surgeons were up to date with their safeguarding training. This had been addressed, and the hospital now kept evidence of mandatory training on their employee files.
- Anaesthetists were provided through an agency. The anaesthetists stayed at the hospital until the patient had recovered and returned to the ward. A telephone number was available at the ward nurses station to call an on-call anaesthetist if required.

# Surgery

## Records

- Care records were managed in a way that kept people safe and ensured they were secure and confidentiality was maintained, even though they were not kept in a single location. Consent documentation, operation notes, ward notes and discharge records were maintained in paper hospital files. Some initial consultation and discharge letters were kept with the patient file, however some letters were kept by the medical secretaries.
- In all locations the records were stored securely and managed in a way that maintained confidentiality. At the last inspection the hospital had planned to move over to electronic record keeping, but this had not yet happened.
- The RMO (Resident Medical Officer) told us the information needed to make timely decisions about patient treatment was available when it was needed
- We reviewed six sets of medical notes. Most records were written in a clear and legible way. One record relating to cosmetic surgery included a consent form with handwriting that was not legible. There was minimal information about the psychological evaluation of patients receiving cosmetic surgery on the consent form, although in some cases there was further information in letter sent to the patient and the GP following the initial consultation.
- Discharge summary records were used to send information about the patient's treatment to their GP. These contained information about the patients' surgery, medication and recovery plan.
- Information about implants were sent to the breast and cosmetic implant registry to enable patients to be contacted in the event of a product recall. Posters were displayed around the hospital advising patients of this.
- Record-keeping tools were available to medical and nursing staff to facilitate rapid review of records and handover of information and to reduce clinical error. This was in the form of a kidney-shaped stamp applied to medicine records of patients with acute kidney injury, and coloured pro-formas for sepsis and urinary tract infection (UTI) screening. General templates were used throughout the patient stay to ensure appropriate information gathering, such as consent forms, observation charts and care records.
- All medicines for patients were authorised by prescriptions completed by the medical or surgical staff. A list of unlicensed or off-label medicines which had been approved by the medical advisory committee were kept in the pharmacy. There was a process to ensure that approval was given before the medicines were dispensed.
- There were arrangements in place for the provision of pharmacy support. The hospital employed a full time pharmacy assistant and had a service level agreement with a larger pharmaceutical company to provide a qualified pharmacist for 30 hours per week. The pharmacy assistant prepared and dispensed medicines under the direction of the pharmacist for in-patient use and to take out (TTOs).
- During drug rounds, red tabards were usually used to prevent disturbance and minimise the risk of error. During the inspection these were not used and we were told they were out of stock. In-patient medicines were stored securely and administered on time. Medicines were kept in locked medicine cupboards there were policies and standard operating procedures available to ensure they were managed in line with relevant legislation.
- The pharmacy team prepared frequently used TTO pre-packs that were held on the ward for use out of hours. The service was unable to demonstrate how they ensured consistency in the preparation of these TTO pre-packs and nursing staff told us that they sometimes adjusted the quantities in the TTO pre-packs to reflect the patient's needs. Therefore, we were not assured the use of TTO pre-packs reflected best practice.
- When the pharmacy was closed, all other medicine requirements, including TTOs not in pre-packs, were handled by the resident medical officer (RMO) and nursing staff. Two nursing staff dispensed medicines from the pharmacy, or in the case of controlled drugs it had to be a nurse and the RMO. Nurse dispensing from pharmacy was not provided for within the hospital's medicine management policy and there was no standard operating procedure for this activity.
- Leaflets were provided about common medicines, how to take them effectively, common side effects and how to manage the side effects.
- Controlled drug registers on the ward and theatres were completed to a good standard and the register in pharmacy was audited twice a month. A key was used for the drug safe on the wards and there was a signing book to monitor who has the key at all times. During the

## Medicines

# Surgery

inspection, a small number of names and times were missing in the key log book. This issue had also been picked up by the pharmacist during audit and staff had been reminded to fully complete their entries.

- Hospitals have a responsibility to promote responsible antimicrobial stewardship, which involves the appropriate use of antibiotics to improve outcomes and reduce resistance to antibiotics. Brightly coloured stickers were applied to the records of patients started on antibiotics detailing the symptoms, focus of infection, start date and detail of antibiotics prescribed, and a date for review. The infection control lead nurse expected patients started on antibiotics were only given a three day initial supply. This ensured the antibiotic was reviewed to ensure they were necessary and the appropriate one was used. The lead nurse monitored all use of antibiotics and cross-referenced these with the recorded incidents of infection.
- Drug refrigerator temperatures were recorded daily and there was a protocol for how to respond if the temperature fell outside of the acceptable range. Medicines relating to radiology were stored appropriately and temperatures were monitored where necessary. Some drugs were kept in temperature controlled cupboards and stock checked daily. A refrigerator lock in one theatre was not working. This was managed by removing drugs to recovery when the theatre was not in use. The temperature of the blood storage fridge was linked to bleeps held by staff to ensure prompt attention if the temperature fell outside of normal range.
- The organisation required that checks took place on patients following admission to ensure that their medicines had been recorded and commenced accurately and in accordance with their prescriptions. These reconciliation checks were completed by the pharmacist. Compliance with this standard was checked through monthly audit with the aim of completing them within 24 hours. On most months the checks were shown to be completed within 24 hours around 70% of the time with many of the omissions happening at the weekend when there was no pharmacist on duty. The hospital's medicines policy does not stipulate a timescale for reconciliation.

## Incidents

- The hospital learned when things had gone wrong through investigation of incidents. Staff reported

adverse events on an on-line reporting system. There was a healthy culture of reporting where staff understood what they needed to report, found the system easy to use and they could also add risks in their departments directly onto the risk register. Some staff told us that they did not receive verbal feedback when they reported incidents, however they were able to review their report on-line to see the outcome if they wished.

- During the inspection we found evidence of new processes which had been implemented following incidents that had occurred. We saw staff engaged with incident management process and were keen to adopt changes to practice which would ensure the same thing did not happen again.
- Serious incidents were investigated thoroughly by managers. Serious incidents are those where serious harm or death occurred, or could have occurred, from an incident. We found that the hospital graded a wide range of incidents as serious incidents and completed root cause analysis investigations to understand if the events had been avoidable. This included incidents where unplanned or unpredicted events had occurred during the course of treatment, such as infections or bleeding following surgery, as well as those where an error had occurred. In the year before the inspection the hospital had completed 35 serious incident investigations, two of these had resulted in moderate harm to the patient and none had involved serious harm or death to the patient.
- We reviewed two serious incident investigations and found they had been investigated thoroughly using root cause analysis. Appropriate recommendations had been made and a timescale for completion of each action was determined. We followed through some of these recommendations and could see where changes had been implemented in the hospital as a result. Learning from incidents was cascaded to staff in a 'Lessons Learned' publication written by the hospital's quality improvement lead.
- The hospital had signed up for the corporate 'Speaking up for Safety programme'. This was a Ramsay programme aimed at improving safety cultures and introducing training programmes within the hospital. The programme aimed to develop the personal skills staff required to raise issues when they are concerned about patient safety.

# Surgery

- 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. Patients who had been involved in serious incidents had been contacted and had received details of the outcome of the investigation with an apology. They were also offered the opportunity to discuss the findings in person. The hospital’s handling of such incidents met the regulatory requirements.
- Staff felt informed, engaged and supported by their senior managers. They had an open relationship and staff said that the senior leaders were visible and approachable. We were told by clinical staff that they saw the hospital director at least daily and had frequent contact with the matron. Staff said they felt comfortable raising concerns and challenging leadership decisions. The hospital director said that they aimed to create a flat organisational structure where staff felt close to senior managers and relationships were not affected by seniority.

## Safety Thermometer

- The safety thermometer is a national tool used for measuring, reporting and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (blood clots in veins). Data from the safety thermometer was collected by the hospital and was discussed at clinical governance committee and with the local CCG. It is also on display in the clinical areas. For the 12 months prior to the inspection, the safety thermometer score was 98% for the hospital which was better than the national average.

## Are surgery services well-led?

Good 

We rated well-led as **good**.

## Leadership

- Strong and stable leadership existed in the hospital. The senior management team were motivated and worked well together with a shared purpose. They had the skills and experience required to drive improvement and had the confidence of their staff.
- Senior managers were driving ongoing and creative improvements at the hospital. They had ambitious and achievable goals and were introducing new and innovative models of care. There had been recent refurbishment at the hospital and it was clear patient experience had been carefully considered during the planning. The result was a two stage recovery area for minor procedures, and the creation of a new patient lounge with comfy reclining chairs where patients could be observed prior to discharge.

## Vision and strategy

- There was a clear vision and strategy for the hospital looking at quality and financial sustainability. A five-year corporate business plan had been published in 2014. In addition to this, there was a two-year business plan specific to New Hall which looked at a range of quality improvement and business growth opportunities. There were short and long term plans. These included growing cosmetic services, becoming a centre of excellence for spinal surgery and supporting local NHS services in meeting surgical referral targets. There were specific strategic objectives and an action plan describing how they planned to meet them.
- Plans targeted both the private care needs of the local population and NHS demand which extended across seven commission groups across the south and south west region. Given the increasing volume of NHS spinal patients seen at the hospital, there was a drive to be considered as equally relevant to national research and improvement programmes as their regional NHS counterparts. Plans were discussed with staff at quarterly open forums.

# Surgery

- The hospital had also developed a specific clinical strategy which was under review at the time of the inspection. This had ten commitments focused on health and wellbeing, care and quality and funding and efficiency. The strategy listed their commitment, what they would do and how they planned to do it. The manager was tasked with reviewing the strategy and identified it was currently complex in design. The registered manager was planning to simplify it to make the messages shorter and clearer.
- The Ramsay group promoted 'The Ramsay Way.' This consisted of a list of beliefs and values which formed their business culture. There were posters on display around the wards advertising the 'Ramsay Way' to staff and patients. The values were well-embedded within the staff group. The hospital also promoted the '6 C's' described by NHS England of care, compassion, competence, communication, courage and commitment.

## Culture

- Staff at all levels treated each other with courtesy. There were good working relationships between department heads and the hospital managers, they communicated effectively and there was a sense of collective responsibility. The working environment was one where challenge was encouraged, and concerns were discussed openly and constructively.
- The culture at the hospital was one where safety and patient experience was prioritised. Staff said they often received positive feedback from patients and found this to be a key motivator. The hospital manager had taken action where concerns about performance had been identified. We were given an example when behaviour from a colleague had caused difficulty and the matter had been escalated until the situation had been successfully resolved. We were given further examples where non-compliance with organisational requirements had been directly addressed.
- Staff were overwhelming positive about working at the hospital. Staff referred to their colleagues as being a large family, and some members of staff had recruited friends and family to come and work there. Morale was high across most departments and staff were proud in their work. The exception to this was radiology where

morale was lower. Some staff we spoke to in radiology felt overwhelmed with work, less appreciated and unable to do a good job due to staff shortages. The hospital was recruiting to address the shortfall.

- Staff felt supported by their managers and found them to be approachable. Managers laid on events to make working life enjoyable and promote wellbeing. All staff were given chocolate eggs at Easter, there had been a social event to mark their 35 year anniversary, and there had also recently been doughnut days and a barbeque. There was a cycle to work scheme and arrangements whereby staff could sell or buy annual leave. The hospital gave rewards to staff for every five years of service, including a financial bonus and additional annual leave.
- The management team understood the Workplace Race Equality Standard (WRES) and submitted data about their WRES indicators. Of the staff working at the hospital, 6.82% had a black minority or ethnic (BME) background. In the 12 months prior to the last report, no BME staff had reported discrimination, harassment, bullying or abuse from staff or patients, relatives or families. There was equality between white and BME staff in the percentage of staff who believed there were equal opportunities for career progression at the hospital. There was a corporate equality duty report which detailed organisation-wide actions.

## Governance

- There was an effective framework of governance at the hospital with a committee structure defined by the corporate group. Their risk management policy had been reviewed in July 2017.
- The hospital complied with the quality assurance processes set by the Ramsay organisation and used the tools available to them effectively. Hospital and departmental risk registers were used to monitor and escalate risks and those on the register correlated with the concerns mentioned to us by staff.
- Clinical governance at the hospital supported the delivery of safe and high quality care. This was overseen by Clinical Governance Committee and Medical Advisory Committee. They reviewed quality information including incidents, local and national audit outcomes, new risks, infection control records and new guidance. Minutes from other local governance meetings, including health and safety and infection control committees are also reviewed. Both committees meet regularly and are

# Surgery

well-attended. We were assured there were systems to monitor the clinical outcomes from individual surgeons, and were given examples of when the hospital and wider organisation had taken action to reduce risks when they had been identified. Due to the high volume of spinal procedures undertaken, the hospital had also introduced a weekly spinal multi-disciplinary meeting where outcomes and complications could be reviewed. A quarterly review of spinal service was also undertaken. This included a review of commissioning arrangements, activity and frequency of surgical complications.

- We saw evidence of learning across the hospital from problems which had arisen. We looked at two serious incidents and saw improvements had been made to prevent recurrence. We also saw incidents had been widely discussed across committees and between staff. When audits were undertaken, recommendations were made and the hospital monitored these to ensure that actions were followed through.

## Managing risks, issues and performance

- There were clear assurance systems and structures at the hospital aimed at identifying, managing and escalating risks. Quality outcomes were closely monitored, they were discussed widely and the various assurance meetings including Clinical Governance, Health and Safety and Medical Advisory Committees. These processes led to quality improvements.
- Surgical outcomes and complications were closely monitored. The hospital recorded all incidents of infections, haemorrhage and returns to surgery and complied with national reporting requirements. They also participated in national audit programmes, including the Patient Reported Outcome Measures (PROMs), the National Joint Registry, British Spinal Registry, the Private Healthcare Information Network and Getting it Right First Time (GIRFT). The results were monitored by the Clinical Governance Committee.
- The hospital was open and transparent with its safety performance and produced a quality account (report) bi-annually. This was made available for the public on the hospital website.
- There was a comprehensive audit programme to ensure quality was measured within the hospital. Results from all the audits were collected on a single on-line audit tool which was overseen and by a senior manager and could be shared with corporate leads. Audit compliance was high. During the inspection we saw that audits were

mostly completed at the designated time. Only one delay was identified but this had been due to staff sickness and was due for completion soon. Staff were trained to complete audits and steps had been taken to maintain rigor. For example, infection control audits were completed by people in different job roles. Handwashing audits had been recently overseen to ensure auditors were correctly identifying opportunities for handwashing.

- There was a central action plan linked to the audit tool which showed the action identified in response to compliance issues. It also recorded the person tasked with the action and confirmed when the action had been completed. This was overseen by the clinical services manager. Results from audits were discussed across the various committees. Actions from audits had been discussed in ward and theatre team meetings.
- There was an effective and comprehensive system to identify and address risks in the hospital. Risk registers were used to record hospital and departmental risks and senior managers were aware of the risks in their departments. New risks were reviewed at least monthly at clinical governance meetings and most showed evidence of active control measures. We saw one risk which had been on the register since 2015 but had not been addressed. This related to a contract issue and had been escalated to the appropriate manager within the corporate group.
- Financial controls and responsibilities were shared between the local and corporate teams. Capital expenditure was governed by the corporate team and there was recent evidence of investment and expansion of services. The hospital was not particularly vulnerable to seasonal variations in demand, however could potentially be affected by changes to regional commissioning of surgery. The hospital manager was able to demonstrate how plans for service development was closely aligned to predicted future activity how they had endeavoured to structure their business to mitigate the risks of income variation.
- There was a detailed business continuity plan detailing how the hospital would respond to critical incidents such as fire, floods and explosions. It also included protocols on how to manage bomb threats.

## Managing information

- Data was collected and used in a way which provided senior managers with the information needed to make

# Surgery

decisions about quality, finance and operations.

Information was used effectively to measure performance and outcomes and identify areas that could be improved.

- Information was shared with staff so they were up to date and understood their own performance of that of their teams. Staff could track their mandatory training, meeting minutes were shared on notice boards and learning from incidents was shared through a 'Lessons Learned' publication.
- The tools used for training, audit and risk management were utilised effectively to assist staff and managers in measuring and improving quality. At the time of the inspection, the training system was not operating effectively. We were told this was a temporary problem. We saw how staff could track their own training activity and see when they were next due to complete update training. The system used for risk management allowed staff to track their incident reports and view the feedback received. The tool used for audit allowed managers to record audit outcomes and manage hospital's audit action plan.
- The electronic patient record was in development but was not yet in full operation. The hospital still stored patient records using a mixture of hospital files, electronic record and consultant files. Staff knew where to find information when it was needed. The resident medical officer told us the relevant information was available when it was needed to treat patients. Records were stored securely and in a way that maintained patient confidentiality.

## Engagement

- The hospital has produced a patient diary which was to include all essential information the patient needs to know about their care. This would also include a space for the patients to write down their comments and concerns. The patient diary also included a patient questionnaire. This had not been introduced at the time of the inspection, but was due to be rolled out in June 2018.
- The hospital collected feedback from patients via the friends and family questionnaire and used this information to shape the service and inform decision-making. Response rates were lower than they would like. The hospital was considering ways of improving this through the customer quality group.

- We saw examples of productive collaboration and engagement with commissioners, local acute hospitals and the local authority when planning and delivering the service. For example, the local authority had been consulted over the content of safeguarding training, and there had been recent collaboration with an acute trust over the development of a new symptom tracker for urinary tract infections. Close relationships with commissioners had allowed the hospital to focus their expenditure in areas where the need in the NHS was greatest, such as spinal procedures.
- The hospital engaged with employees in a variety of ways. A staff survey was carried out every two years, asking questions about how they feel about matters such as their working environment, pay and recognition and their opportunities for development. Scores were benchmarked against a range of employers. The latest staff survey was conducted in March 2016 and staff scores were positive in most areas. There was a one low score of 38% which was for questions relating to the corporate leadership team. This correlated with what some staff told us, that they sometimes did not feel their work or achievements were recognised by the corporate team. Questions looking at satisfaction with the hospital's leadership team scored better at 69%.

## Learning, continuous improvement and innovation

- The hospital had a culture where continuous improvement was valued and encouraged. New procedures were discussed by the Medical Advisory Committee and funding was provided for new clinical equipment. Examples included new equipment for eye surgery and new sensor controlled sinks in patient bedrooms to improve infection control.
- Learning was encouraged amongst staff and opportunities for learning and development were made available through the Ramsay Academy. We were told by a new member of staff how impressed they were by the opportunities for growth and development that were available at the hospital. The member of staff felt confident there were good career opportunities. We found clinical staff were more familiar with the academy, whereas some of the administrative and non-registered staff did not feel that the academy offered as much for them.
- Senior managers supported staff with ideas on how to improve the hospital's practice. In the ward area there

# Surgery

was an innovation board where staff could put forward their ideas. We were shown some new processes that had been introduced by staff, including a new system to improve the safety of medicines for patients with acute kidney injury and a new process of recording the chaperone arrangements for patients. The lead nurse for infection control was also introducing a new trial for using negative pressure wound therapy on surgical wounds to improve healing and reduce infections. A review of indwelling catheters was also being undertaken to identify ways of reducing infections.

- Plans for larger innovations and improvements were also seen during the inspection. These included a new ambulatory care unit to allow for the more efficient flow of patients requiring minor procedures. Patients remained clothed and hospital beds had been replaced with two stage recovery area, including a recovery lounge where patients could sit in comfy chairs.

# Outstanding practice and areas for improvement

## Outstanding practice

- The leadership team at the hospital created a strong and sustainable business culture based on quality, clinical excellence and continuous improvement. Staff respected their leadership team and they shared a collective responsibility to improve services, create a good environment for patients and deliver excellent care. Managers had a proactive approach to patient safety by continuing to identify opportunities to make the hospital safer but, when things went wrong, they reviewed and improved services.

## Areas for improvement

### Action the provider SHOULD take to improve

- Bring staff up to date with their mandatory training
- Implement peri-operative temperature monitoring for patients undergoing surgery in line with national best practice guidance.
- Consider reviewing the use of carpets in the patient rooms to make easier to keep floors clean.
- Consider how to address low morale amongst the radiology team.
- Check staff adhere to the uniform policy and remain bare below the elbow in clinical areas.
- Risks escalated to the corporate team should be updated when reviewed and a record kept of control measures.
- Improve storage space to create a better and safer working environment.
- Use six-use tourniquets in accordance with manufacturer's instructions
- Review the practice of nurse-dispensing from the hospital pharmacy to ensure that activity falls within the organisation's policies.
- Review the management of 'to take out' (TTO) medicines to ensure that they are prepared and handled in line with best practice guidance.