Parkside Hospital

Quality Report

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Date of inspection visit: Announced visit took place 24-26 May 2016. Unannounced visit took place on 6 June 2016.
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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

This was the first comprehensive inspection of Parkside Hospital, which was part of the CQC's ongoing programme of comprehensive, independent healthcare acute hospital inspections. We carried out an announced inspection of Parkside Hospital on 24-26 May 2016. Following this inspection an unannounced inspection took place on 6 June 2016.

The inspection team inspected the core services of medicine, surgery and outpatients and diagnostic imaging services.We did not inspect end of life care as a separate core service as it accounted for less than 10% of the services provided at the hospital.

Complex diagnostic investigations such as magnetic resonance imaging (MRI) and computerised tomography (CT) scans were provided by the hospital.

Overall, we have rated Parkside Hospital as good. We found medicine good in all five of the key questions we always ask of every service and provider relating to safe, effective, caring, responsive and well led. Outpatients and diagnostic imaging services was rated good in the four key questions relating to safe, caring, responsive and well led. We inspected but did not rate the key question of effective in outpatient and diagnostic imaging services. We found surgery services were good in four of the key questions of safe, effective, caring and responsive, but requires improvement in well led.

Are services safe at this hospital/service

By safe, we mean that people are protected from abuse and avoidable harm.

- There was a positive culture of incident reporting. Nursing staff understood their responsibilities to raise concerns and report incidents and were supported when they did so.
- There was an effective process for the investigation of serious incidents and a good understanding and use of the Duty of Candour. Staff told us they would apologise and inform the patients or their carers if incidents occurred.
- All patient areas were visibly clean. Infection prevention and control processes were adhered to and equipment had been cleaned and had green labels attached to them in line with the hospital's policy.
- The hospital monitored patient safety on a day-to-day basis and patients were safeguarded from harm. Staff were aware of their safeguarding adult's responsibilities. Patients were appropriately escalated and treated if they deteriorated. Medicines were well managed, stored and administered safely.
- Staffing levels and skill mix were planned, implemented and reviewed to ensure patients received safe care and treatment at all times.
- Patients were appropriately risk assessed, their condition was monitored throughout their stay, and there were appropriate procedures and protocols for responding to any deteriorating condition.
- Improvements were needed to the anaesthetic cover of the High Dependency Unit.
- Medicines were managed and stored safely.
- Staff had received up-to-date relevant mandatory training which was relevant to their role, this included level three safeguarding children's training.
- Some patients did not receive a pre-assessment prior to their operation and this meant that there was a risk that a patient could deteriorate unexpectedly during or after their surgery leading to an unplanned admission to the High Dependency Unit or an emergency transfer.
- There were arrangements for RMO to RMO handover using the situation, background, assessment, recommendation (SBAR) system.

Are services effective at this hospital/service

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

- Patient care and treatment reflected relevant research and guidance, including the Royal Colleges and National Institute for Health and Care Excellence (NICE) guidance.
- Staff were well supported with access to training, clinical supervision and development. RMOs told us they felt well supported by the senior medical staff and had access to regular training.
- There was an effective multidisciplinary approach to care and treatment with good communication between the teams and out-of-hours services were provided when needed.
- Patients had comprehensive assessments of their needs, which included assessment of their clinical needs, physical health, nutrition and hydration needs.
- Patient's needs with regard to pain management were addressed. Patients had access to different methods of pain relief. Patients' pain was monitored and the effectiveness of pain management evaluated.
- Awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards was limited amongst some staff groups.
- Audits and outcomes of care and treatment were monitored and actions were taken to make improvements.
- There was a good multidisciplinary team approach to care and treatment. This involved a range of staff working together to meet the needs of patients using the service.
- There had been a low level of documented consent within the outpatients department for minor procedures. An audit had been introduced to monitor this and actions were being followed up in order to improve compliance.

Are services caring at this hospital/service

By caring, we mean that staff involve and treat patients with compassion, dignity and respect.

- Patients received supportive care and treatment.
- The views of children and young people using the service were requested in an appropriate way.
- Interactions between staff and patients were positive.
- The patients we spoke with told us staff were very caring and respectful, and patients felt they were supported emotionally.
- Patients understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.
- The service was rated very positively in patient feedback provided.

Are services responsive at this hospital/service

By responsive we mean that services are organised so they meet people's needs.

- Services were planned and delivered to meet the needs of the local population. New services had been introduced in specific response to local demand.
- The flow of admissions and discharges through the hospital was well organised. Oncology and end of life care patients were able to access services when needed and these services were responsive to their individual patient needs.
- Patients had their needs assessed and essential care rounds were undertaken at different times of the day. Patient care was planned and one to one observations were carried out on patients on the oncology and end of life care ward. Patients who had complex needs or who were at risk of deterioration were supported during the day and night with appropriate treatments.
- Patients were aware of how to make complaint or to provide feedback about the service if needed. Complaints and concerns were taken seriously, responded to in a compassionate way, investigated in a timely manner and learning taken to improve future practice. Nursing staff were aware of learning from complaints across the hospital. There was evidence that lessons had been learnt and actions taken as a result.
- We reviewed the provider's complaints process and this showed that complaints were easy to make, risk assessed, thoroughly investigated, recorded and support was provided to complainants. However, improvements were required to ensure that in most cases, people felt that their complaint made a difference.

Summary of findings

- There were facilities available for people from different cultural backgrounds and for whom their first language was not English.
- Services coordinated appointments to enable patients to see a number of health care professionals in one day.
- Patient's individual needs were taken into consideration when planning care.
- Waiting times for outpatient appointments were within the national referral to treatment time target of 18 weeks.
- Vulnerable adults, such as patients with a learning difficulty and those living with dementia were identified at the referral stage and steps were taken to ensure they were appropriately cared for. This included a longer appointment time and informing carers or representatives of the plan of care.

Are services well led at this hospital/service

By well-led, we mean that the leadership, management and governance of the organisation, assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- There were quality issues within the service which had been flagged for a substantial period of time by the service's governance, but at the time of the inspection, they had not been resolved and a clear plan for doing so was not apparent.
- Aspects of the governance system, including the training and workforce activity data, did not provide accurate information and this had to be collected manually which hampered the service's ability to monitor these aspects.
- There was a clear statement of vision and values, driven by quality, with defined objectives that staff understood. However, the oncology and end of life care service did not have a written strategy for the service to deliver the vision of the hospital.
- The senior management team displayed characteristics of the hospital vision and values on a daily basis.
- Staff were focused on providing the best service they could for all patients regardless of whether the patient funded themselves or was insurance or NHS funded.
- Staff told us that senior and local managers were visible and approachable.
- Staff spoke positively of the open culture within the service and said that senior staff would act on their feedback.
- The service actively engaged individual patients and acted on their feedback.
- There was an open, positive and supportive learning culture, with competent local leadership and a happy work force.
- Patients were given opportunities to provide feedback about their experiences and this was used to improve the service.

We saw several areas of outstanding practice including:

- Changing the pre-assessment for patients having breast surgery to involve a breast care nurse to provide additional emotional support and practical information.
- The 'one-stop clinic' operated by the radiology department and breast surgeons operated three to four times per week whereby patients could have a consultation, mammography and ultrasound with options for additional interventional procedures if required during one appointment.
- A feedback questionnaire compiled by the provider for services provided for children and young people asked both parents and children for their opinions with an appropriate language style for children.

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

The provider must:

- Report all patient deaths, both expected and unexpected, that occur at the hospital to CQC.

The provider should:

Summary of findings

- Speed up the JAG accreditation process for their endoscopy unit.
- Document and monitor place of death data in order to ascertain how well the service was performing against key benchmarks of the Hospital.
- Implement a written strategy for the oncology and end of life care service to deliver the vision of the hospital.
- Develop a protocol for informing GP's about their patients requiring community end of life care.
- Review how they share incidents where patients have deteriorated and review the policy for pre-assessment to make sure all patients who require a pre-assessment have one carried out to the appropriate level.
- Review the treatment area and gym within the physiotherapy department to improve patient privacy and dignity.
- Ensure all relevant staff are made aware of the learning from never events and incidents.
- Address the nursing staff vacancies, particularly in the recovery suite.
- Improve the anaesthetic cover of the High Dependency Unit.
- Improve staff awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Resolve the ongoing quality issues flagged by the governance system.
- Improve the quality of training and workforce activity data collected by the internal automated systems.

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	We rated medical care as 'Good' because: • The hospital had systems in place to keep patients safe. Staff knew how to report incidents, incidents were reported, investigated, fed back to staff, lessons were learnt and learning was applied. • Oncology and end of life care was planned and co-ordinated effectively. There was a strong governance arrangement that promoted safe practice. • Patients were complimentary about the care they received and patients with complex needs were supported and their families were encouraged to attend and stay with them. Staff felt valued and listened to by the ward and hospital management. • Treatment was provided in line with national guidance and staff were aware of the NICE guidance related to oncology and end of life care. • Patients received treatment which considered their levels of pain and their nutritional and hydration needs. Policies and procedures were in place to support staff. • Services were planned to meet patient's needs. Most of the patient feedback we received was positive including involvement in care and privacy and dignity. • Staff were seen to be kind and caring and their focus was on individualised patient care. Patients who deteriorated or were in pain were well managed and patient harm was being actively reduced. • Complaints were responded to and acted upon. There was good local leadership at ward and department level. • Staff were aware of the hospital's vision and incorporated this as part of their daily work. The culture within the oncology and end of life care services was of openness and honesty.
Surgery	Good	We rated this surgery as 'Good' because:

Summary of findings

- Care and treatment were provided in a clean environment according to national standards.
- There were appropriate levels of suitably trained staff.
- Patients were treated with kindness, courtesy and respect.
- The service could be accessed easily and there were no delays to discharges.

However:

- The service needed to actively tackle some of the issues flagged by the governance system and improve the quality of data collection of aspects of the system itself.

Outpatients and diagnostic imaging

Good

We rated outpatients and diagnostic imaging as 'Good' because:

- There were systems to protect patients from avoidable harm and abuse. Staff knew how to report incidents and lessons learned from these incidents were shared within teams.
- All patient areas were visibly clean, infection prevention and control processes were in place and equipment had been checked regularly.
- Staff completed mandatory training courses with good compliance rates and staffing levels were appropriate to meet the needs of patients.
- Staff providing care to children and young people had received annual training in paediatric competencies and there were appropriate plans if the condition of a child deteriorated whilst they were at the hospital.The service was working on updating policies to incorporate the new NICE guidelines for pre-operative assessment, and evidence based treatment was delivered by competent staff.
- We observed effective multi-disciplinary working and saw that consent documentation was being closely monitored with improvements made to compliance levels.
- Patients were very positive about the care that they received and the information provided to them.
- Patients were treated with dignity and respect while they attended the hospital.

Summary of findings

- Staff were enthusiastic about the service they provide and we observed positive interactions between staff and patients.
- Waiting times for outpatient appointments were within the national guidelines, with minimal waiting times in some specialties.
- Patients' needs were met through the way services were organised and delivered, such as providing a longer appointment time for patients with additional needs.
- The leadership of the service was good. Local and senior leadership was visible and there was appropriate management of quality, governance and risk. Staff were proud to work for the service.

Summary of findings

Contents

Good

Parkside Hospital

Services we looked at

; Medical care (including oncology and end of life care); Surgery (including Critical care); Outpatients and diagnostic imaging (including Services for children and young people)

Summary of this inspection

Background to Parkside Hospital

Parkside Hospital opened in 1983 and has 84 beds comprising of 64 ensuite overnight rooms and 10 day beds. There are also four operating theatres, five HDU beds and 32 consulting rooms. Parkside Hospital has been providing healthcare for 33 years, and is part of Aspen Healthcare Limited.

Parkside Hospital mainly provides privately funded treatments, but also undertakes some work for the NHS. Most of the hospital patients live in and around the South West London area. The hospital offers a range of surgical procedures, including orthopaedics, uro-gynaecology and plastics. It also offers cancer care, diagnostic and imaging and a physiotherapy service. Children and young people are treated at the hospital, but only those above aged three are admitted. Patients are admitted for elective surgery, day case or receive outpatient care. There are no urgent admissions.

Parkside Hospital offers physiotherapy treatment for inpatients and outpatients in its own dedicated and fully equipped physiotherapy suite and hydrotherapy pool.

We inspected Parkside Hospital as part of our planned comprehensive inspection programme. We looked at three core services provided by the hospital: medical care (including oncology and end of life care), surgery (including critical care) and outpatients and diagnostic imaging (including children and young people). We did not inspect end of life care as a separate core service as it forms less than 10% of the total medical services been provided by the hospital.

The registered manager is Hilda Bradbury, registered in 2005.

The nominated individual from Aspen Healthcare Limited Ltd is Judith Ingram.

Our inspection team

Our inspection team was led by:

Inspection Lead: Roger James, Inspection Manager, Care Quality Commission

The team included three CQC inspectors, an assistant inspector and a variety of specialists: two consultant surgeons, an orthopaedic registrar, two nurses, a physiotherapist, a radiographer, a pharmacist inspector and an expert by experience.

How we carried out this inspection

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

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

Before our inspection, we reviewed a range of information we held about the hospital and each core service.

We carried out an announced inspection between 24 and 26 May 2016 and an unannounced inspection on 6 June 2016. During our inspection, we spoke with members of staff of all grades, including consultants who were not directly employed by the hospital, patients and relatives who use the hospital services. We visited all clinical areas and observed direct patient care and treatment. We also reviewed how medicines were managed.

We received 34 comment cards from patients and relatives during the inspection. The majority were very positive about the service they received. We reviewed the provider's complaints process and looked at four patient records who had made complaints.

Summary of this inspection

We attended the hospital's quarterly Medical Advisory Committee (MAC) meeting on 25 April 2016. We held planned focus groups with clinical and non-clinical staff on 18 May 2016, to allow staff to share their views with the inspection team.

We also interviewed the hospital's senior managers, including the registered manager, director of nursing and chair of the MAC. We also interviewed the resident medical officer (RMO).

Information about Parkside Hospital

Hospital activity between January 2015 to December 2015:

- Inpatient activity, 10,658
  - Overnight, 3,061
  - Day case, 7,597
- Visits to theatre, 9,511
- Outpatient activity, 97,698
  - First attendance, 35518
  - Follow up, 62180

The five most common surgical procedures were:

- Multiple arthroscopic operation on knee (725)
- Surgical removal of impacted/buried tooth/teeth (405)
- Phacoemulsification of cataract, with lens implant – unilateral (259)
- Hysteroscopy (194)
- Autograft anterior cruciate ligament reconstruction (161).

The five most common medical procedures were :

- Medical treatment (non-surgical) (907)
- Diagnostic colonoscopy (790)
- Diagnostic oesophago-gastro-duodenoscopy (OGD) (648)
- Diagnostic oesophago-gastro-duodenoscopy (OGD) (as sole procedure) (292)
- Diagnostic endoscopic examination of bladder (cystoscopy) (279)

The accountable officer for controlled drugs is Hilda Bradbury, who is also the registered manager.

Detailed findings from this inspection

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	Good	Good
Surgery	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Good

Medical care

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

Information about the service

Parkside Hospital provides a range of medical care services to both private and NHS patients and has 15 inpatient beds on the third floor of the main hospital dedicated for oncology and end of life care. Medical services provided include clinical haematology, medical oncology (including direct admission for oncology patients with complications of chemotherapy), palliative and end of life care. In the period between January 2015 and December 2015, the hospital admitted 3061 patients of which 356 were NHS patients.

We inspected the oncology and end of life care ward, and spoke with four patients including their family members and carers, 13 staff members including, doctors, nurses, therapists and support staff. We also spoke with management at various levels from ward to divisional level.

The endoscopy suite operated between 7am and 7pm Monday to Friday and consisted of a treatment room and a decontamination room. Patients undergoing endoscopy were admitted via the day care unit and also had their recovery at the day care unit, post their procedure.

We observed interactions between patients and staff, observed the environment and reviewed seven care records. We received comments on cards from people who used the service and from people we spoke with during the onsite inspection, to tell us about their experiences.

Information provided by the hospital prior to our inspection was reviewed and used to inform our inspection approach. We received comments from various staff at the focus groups we held at the hospital.

Summary of findings

We rated medical care as 'Good' because:

- The hospital had systems in place to keep patients safe. Staff knew how to report incidents, incidents were reported, investigated, fed back to staff, lessons were learnt and learning was applied.
- Oncology and end of life care was planned and co-ordinated effectively. There was a strong governance arrangement that promoted safe practice.
- Patients were complimentary about the care they received and patients with complex needs were supported and their families were encouraged to attend and stay with them. Staff felt valued and listened to by the ward and hospital management.
- Treatment was provided in line with national guidance and staff were aware of the NICE guidance related to oncology and end of life care.
- Patients received treatment which considered their levels of pain and their nutritional and hydration needs. Policies and procedures were in place to support staff.
- Services were planned to meet patient's needs. Most of the patient feedback we received was positive including involvement in care and privacy and dignity.
- Staff were seen to be kind and caring and their focus was on individualised patient care. Patients who deteriorated or were in pain were well managed and patient harm was being actively reduced.
- Complaints were responded to and acted upon. There was good local leadership at ward and department level.

Good

Medical care

- Staff were aware of the hospital's vision and incorporated this as part of their daily work. The culture within the oncology and end of life care services was of openness and honesty.

Are medical care services safe?

Good

We rated safe as good because:

- There was a positive culture of incident reporting. Nursing staff understood their responsibilities to raise concerns and report incidents and were supported when they did so.
- There were processes for investigating incidents and there was a range of suitable fora, like handover meetings and 'huddles' for staff to receive feedback and shared learning. Senior nurses regularly reviewed incidents and shared the findings with individual staff and at team meetings.
- All patient areas were visibly clean. Infection prevention and control processes were adhered to and equipment had been cleaned and had green labels attached to them in line with the hospital's policy.
- The hospital monitored patient safety on a day-to-day basis and patients were safeguarded from harm. Staff were aware of their safeguarding adult's responsibilities. Patients were appropriately escalated and treated if they deteriorated. Medicines were well managed, stored and administered safely.
- Staffing levels and skill mix were planned, implemented and reviewed to ensure patients received safe care and treatment at all times.

Incidents

- An online computer incident reporting system was used to report incidents and staff told us it was easy to report incidents when they occurred. Staff were encouraged to report incidents and felt there was a good culture in reporting.
- Nursing staff had full awareness of the processes to follow in order to report adverse incidents or concerns. Nursing staff we spoke with understood their responsibilities to raise concerns, to record safety incidents and near misses, and to report them internally in order that they could be investigated and acted upon.

- All incidents were reviewed by the director of nursing and the lead cancer nurse. Investigations took place if needed to identify underlying causes and learning was shared at monthly clinical governance meetings.
- There was a process for the investigation and escalation of serious incidents. We saw a report into an investigation of a serious incident of an unexpected death. Root cause analysis (RCA) had been completed and an action plan that had been put in place to avoid similar incidents from happening again. All incidents were discussed at monthly governance meetings, Medical Advisory Committee (MAC) meetings and at acute oncology group meetings.
- Staff discussed incidents reported in the previous 24 hours at the daily handover meetings or 'huddle and cuddle' meetings. These meetings were attended by a representative of each department, and led by the director of nursing or delegated senior manager.
- Mortality and Morbidity meetings were held regularly as part of the multidisciplinary team (MDT) meetings. We saw evidence of mortality and morbidity that had been discussed at these meetings. These were comprehensive and action points and lessons learnt were identified.

Duty of Candour

- 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 were aware of their responsibilities under duty of candour, which ensured patients and / or their relatives were informed of incidents that had affected their care and treatment and they were given an apology. Duty of candour was considered as part of the investigation into serious incidents.
- Nursing staff shared with us an example where they had applied duty of candour when a patient transplant was delayed due to transportation issues. We were told they provided an explanation for the delay and apologised to the patient.

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

- The NHS Safety Thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheters and associated urinary tract infections (CAUTIs). The hospital had monitored performance through a series of assessments to reduce risks to patients. These included falls, pressure ulcers and venous thromboembolism (VTE).
- Safety Thermometer data had been collected on a monthly basis and the results were made available to the wards managers. The rates of pressure ulcers, falls, and CAUTI's reported via the patient safety thermometer were all zero, and showed no distinct trends from January 2015 to December 2015.
- Safety thermometer results were not displayed centrally on the oncology and end of life care ward, for patients and visitors to see the performance of the ward over time, which meant this information was not available to patients and their families. Wards managers told us they did not routinely displayed safety thermometer results on the ward, however, ward performance including safety thermometer results were discussed at staff meetings.

Cleanliness, infection control and hygiene

- The oncology and end of life care ward we visited was visibly clean. We observed support staff cleaning throughout the day and undertaking this in a methodical and unobtrusive way. The ward had daily cleaning schedules, which staff would tick to indicate when specific areas had been cleaned. We saw daily cleaning schedules completed and signed for by the ward staff.
- We saw adequate hand washing facilities and hand sanitising gel were available for use at the entrance to the wards, within the wards and at the entrance of the patient rooms. There was signage on the ward areas, toilets and bathrooms reminding people of the importance of hand washing. We observed that staff generally washed their hands in line with the World Health Organisations (WHO) guidance "Five moments of Hand Hygiene." We saw there were monthly infection control audits; these included an audit of hand hygiene, which showed the ward had 100% compliance for the period of January 2015 to December 2015.

- Adequate supplies of personal protective equipment (PPE) such as gloves and aprons were available and we saw staff using these appropriately when delivering care. We noted that all staff adhered to the "bare below the elbows" guidance in the clinical areas.
- We observed green 'I am clean' labels were in use to indicate when equipment had been cleaned. One of the ward managers reported that staff were encouraged to clean equipment after use.
- The hospital infection control lead nurse provided support, advice and training to staff. They also undertook departmental audits. The monthly infection prevention and control audit for the ward showed 100% for compliance with the management of sharps to prevent infection and cross contamination. Infection and Prevention Control training formed part of the mandatory training programme and was updated annually. The oncology and end of life care ward staff had all completed their infection control training.
- We noted that management of sharps 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.
- The hospital had a service level agreement (SLA) in place with an external provider for the disposal of all waste materials including clinical waste and sharps waste. We observed clinical and domestic waste was appropriately segregated and there were arrangements for the separation and handling of high risk used linen (contaminated linen). We observed staff complied with these arrangements. Nursing and housekeeping staff safely managed clinical waste and non-clinical waste to ensure segregation and safe disposal. Patient-led assessments of the care environment (PLACE) audits for 2015 showed the hospital had achieved 100% for cleanliness. This was above the national average of 98%.
- The oncology and end of life care ward reported zero (0) incidences of methicillin resistant Staphylococcus aureus (MRSA), Clostridium difficile (C. diff) or methicillin-sensitive Staphylococcus aureus (MSSA) in the reporting period between January 2015 to December 2015. MRSA, MSSA and C. diff are all infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection that is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated. (C. diff is a form of bacteria that affects the digestive system and commonly associated with people who have been taking antibiotics).

Environment and equipment

- Nursing staff said they had sufficient equipment needed and were able to access them when needed to care for their patients. Intravenous pumps were available and had been serviced and stored appropriately.
- Storage facilities for equipment within the ward was well organised. Staff informed us they always had access to equipment they required. Single use equipment such as syringes, needles, oxygen masks were readily available on the ward.
- Water supplies were maintained at safe temperatures and there was regular testing of the water system to minimise the risk of Legionella bacteria colonisation.
- Resuscitation equipment was maintained, in order and ready for use in an emergency. Trolleys were checked daily and records kept demonstrated that checks had been completed. Expiry dates of items were recorded to easily identify items which were due for re-ordering. The trolleys were secured with tamper evident seals.
- Equipment we saw was safety tested. Staff we spoke with were clear on the procedure to follow if they identified faulty or broken equipment and who to report it to.
- The hospital had carried out an audit of all the hospital equipment available at the hospital and showed 100% compliance. Equipment checks we reviewed were up to date including resuscitation trolleys, blood pressure monitors, infusion pumps and syringe drivers. Maintenance records and requests for repairs were also up to date.
- Domestic staff told us they had the correct equipment to do their job and had received health and safety training including training on Control of Substances Hazardous to Health Regulations (COSHH).
- The hospital does not have Joint Advisory Group (JAG) accreditation for its endoscopy service. JAG accreditation is the formal recognition that an endoscopy service has demonstrated its compliance to deliver against the measures in the endoscopy standards. The hospital was working towards this accreditation.

Good

Medical care

Medicines

- The treatment room was clean and tidy, with keys to the drug cupboards and Patient's Own Drugs (POD) lockers held by registered nurses. The door to the room was securely locked with restricted access. Inside the room, we saw cytotoxic (chemotherapy drugs) spillage kits (these are equipment used in the management of chemotherapy drug spillage) and extravasation kit (the equipment to manage the extravasation (accidental) leakage of chemotherapy drugs from its intended vein into the surrounding tissue), within date and monitored. Outside the room, emergency medicines were available and accessible for immediate use, and were in date and tamper proof.
- Small quantities of bulk fluids were stored appropriately in the treatment room. However, the majority of bulk fluids were stored in the main pharmacy (outside the ward), if needed.
- Controlled Drugs (CD) were checked on a daily basis and correctly documented in the CD register, with access to them restricted to authorised staff. We found that stock balances reconciled to the quantities recorded in the register with no discrepancies.
- Resuscitation trolley was available and kept secured when not in use, to keep it safe.
- Room and fridge temperatures were recorded on a daily basis, and were found to be within the recommended range. Nurses were aware of actions to take if the temperatures were outside the normal limits including contacting the pharmacist and estates management.
- There was a policy to support the use of patients own drugs (PODs), and we saw evidence of these appropriately stored in cupboards beside patient bays.
- The ward was visited by a dedicated pharmacist twice a day. They were responsible for screening drug charts, medicines reconciliation, ordering and topping up of drugs from the main pharmacy, ordering the TTO (to take out) medicines for patients and giving information to certain patients on specific medicines usage.
- Staff had access to British National Formulary (BNF's) as well as all policies and information relating to medicines management (including the Antimicrobial Formulary). All medicines related policies were in date.
- Staff competencies for prescribing, dispensing and administrating medicines were assessed by dedicated induction processes provided by the hospital. We found evidence that nursing staff received regular training updates by the pharmacy team.
- Staff understood and demonstrated how to report medicines safety incidents. This was then escalated and fed back for learning through regular meetings with the chief pharmacist.
- We found that allergies were recorded on the drug charts, alongside other sections such as patient identifiable details, syringe pump details and when required (PRN) medicines. We saw evidence of pharmacy input into these drug charts.

Records

- Patient records included multi-professional clinical notes, which included those from physiotherapists, occupational therapist and dietitian to support safe care and treatment. All the notes reviewed were legible and detailed.
- Patients' records were kept confidential and stored securely kept in the nurses' station which doubled up as nurse's office.
- We reviewed seven sets of patient records and found detailed information had been recorded. Information recorded showed the patients had been seen within an hour of admission to the ward, diagnosis and management plans were identified, nursing assessments and care plans had been completed. Risk assessments had also been completed which included pressure ulcer risk assessments, Venous Thromboembolism (VTE), nutritional and falls risk assessments.
- In a completed care record we reviewed, we found clear and concise documentation and a recorded discussion with family members about advance care planning and end of life wishes of their relative.

Safeguarding

- There was a safeguarding children's and vulnerable adult's policy. The director of nursing was the safeguarding lead for the hospital and she was level three trained, so safeguarding issues could be investigated in a management capacity. There were no safeguarding concerns reported in the last year.
- Nursing staff were aware of their safeguarding responsibilities and had specific safeguarding awareness training. They were able to describe different types of safeguarding concerns and abuse and could explain how they would respond if they witnessed or suspected abuse.

Good

Medical care

- All of the staff we spoke with had a clear understanding about the processes and practices that were in place to keep patients safe and safeguarded from abuse at the hospital.
- Data provided by the hospital showed that all oncology and end of life care ward staff had completed level two safeguarding training for adults and had also completed training on Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). There were policies for the MCA and the DoLS available and in date.
- We were told that the ward had never made a DoLS application for any patient. Relevant checks against professional registers, and the Disclosure and Barring Service (DBS) were completed for all staff working on the oncology and end of life care ward.

Mandatory training

- Staff were aware of the mandatory training they were required to undertake. The hospital target was 90% of staff having completed their mandatory training. The oncology and end of life care ward recorded 100% completion of their mandatory training. This was confirmed with all the staff we spoke with.
- Mandatory training included information governance, infection prevention and control, safeguarding adults and children, fire training, consent, Mental Capacity Act 2005, safer blood transfusions, moving and handling, record keeping and health and safety. Staff could access training online and face to face training was available for basic and intermediate life support, manual handling, fire awareness training and aseptic technique.
- Ward managers we spoke with demonstrated the systems they used locally to monitor their staff attendance at mandatory training to ensure it was completed or refreshed when required.
- The hospital had processes in place to ensure consultants working with practising privileges undertook their mandatory training with their NHS employer as part of their appraisal system. The hospital monitored this as part of their review of consultants working at the hospital under practising privileges biennially.
- The resident medical officers (RMOs) received mandatory training via their RMO agency and had access to any local training held at the hospital.

Assessing and responding to patient risk

- Patients' clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' A scoring system known as a national early warning score (NEWS) system was used to identify patients whose condition was at risk of deteriorating.
- All the NEWS records we reviewed showed compliance with completing the necessary observations at 100%. Patient records we reviewed showed patient observations were completed and were appropriately escalated and had medical interventions in a timely way.
- Patients saw their named consultant at each stage of their patient journey. Patient's needs were assessed throughout their stay and in line with their care pathway. A resident medical officer (RMO) was on duty 24 hours a day, seven days a week to respond to any concerns staff may have about a patient's medical condition. All patients in the ward were referred to and seen by the palliative care consultant on admission.
- Staff were aware of to how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for a deteriorating patient. All staff had received training in basic and immediate life support.

Nursing staffing

- The oncology and end of life care ward used the Aspen Healthcare nursing staffing tool to manage their staffing levels, this factored in patient numbers, patients dependency, skill mix and staff training. Typical staff to patient ratio of 1:4 was used on the day of the inspection, with the normal staff and patient ratio being 1:3 on the ward. The ward sister prepared the staff rota monthly in advance and was reviewed on a daily basis to meet the needs of the service.
- All staff we spoke with said there was sufficient staff to meet patient needs. The ward establishment was stable and could flex to the needs of patients. We saw day case surgical patients been cared for on the ward during the inspection and had surgical trained nurse to complement the ward staffing level.
- There were no vacancies in the oncology and end of life care team. However, when needed, regular bank nurses were employed who were familiar with the ward, services provided and local procedures. Staff told us that bank staff when used, provided continuity of care to patients.
- We were told the ward had not used agency nursing staff in the last six months.

Good

Medical care

- There were two trained oncology nurses and one nurse in training for a chemotherapy course at nearby NHS Hospital. There was one healthcare assistant on the ward who provided support to nursing staff when needed. There was consistent and regular members of the ward nursing staff. Nursing staff we spoke with told us they had enough nurses on duty at all times to deliver good individualised care to all patients. Staff told us that they felt staffing was sufficient and the skill mix was right at all times, however on some occasions, when patients became unwell or the wards were busier, bank staff could be requested.

Medical staffing

- A resident medical officer (RMO) was available in the hospital 24 hours a day, seven days a week. The RMO offered medical support to the nursing staff; however nursing staff told us they had no problems contacting individual consultants for information or advice. The RMO was informed of all patients on the ward and we saw that they were included in staff handovers. This ensured they were aware of the nature and acuity of all patients in the ward.
- RMOs liaised with consultants to ensure care reflected individual patient needs. The hospital always used the same RMOs from the same agency to ensure continuity of care and service provision to minimise potential risk. The RMOs worked at the hospital regularly and knew the hospital and its routine well. RMOs were advised of cover arrangements for any consultant on leave.
- All clinical care was consultant led and consultants provided personal cover for their own patients 24 hours a day, seven days a week. They also arranged cover from another consultant with practising privileges at the hospital during annual leave and other leave of absence. Any issues with cover arrangements were raised at Medical Advisory Committee (MAC) meetings. Nursing staff said the consultants were always contactable by phone when needed. Consultants we spoke with confirmed that they were contacted 24 hours a day and can come to the hospital when needed within half an hour to an hour.

Major incident awareness and training

- Staff we spoke with were aware that there was a procedure for managing major incidents or an event that impacted on business continuity. Staff informed us they would follow instruction from their ward manager or the hospital manager who covered the site 24/7 in the event of major incident.
- A major incident policy and plan were in place. A hospital-wide fire alarm test took place on a weekly basis and staff knew when this was planned. Fire awareness training was part of the hospital mandatory training. All staff understood their responsibilities if there was a fire within the building. Staff confirmed that an emergency generator was available and was also tested weekly.

Are medical care services effective?

Good

We rated effective as good because:

- The hospital had policies and procedures that took account of evidence-based NICE guidance and national standards.
- Staff were well supported with access to training, clinical supervision and development. RMOs told us they felt well supported by the senior medical staff and had access to regular training.
- Consultants covering oncology and end of life care were available seven days per week. Ward staff had access to a full range of allied health professionals such as occupational therapists, dietitians and physiotherapists to support patient care and treatment.
- There was an effective multidisciplinary approach to care and treatment with good communication between the teams and out-of-hours services were provided when needed.
- Patients had comprehensive assessments of their needs, which included assessment of their clinical needs, physical health, nutrition and hydration needs.
- Patient's needs with regard to pain management were addressed. Patients had access to different methods of pain relief. Patients' pain was monitored and the effectiveness of pain management evaluated.
- The hospital documented preferred place of death and audited how well the service was performing on documenting a preferred place of death.

However:

- The hospital's endoscopy unit was not Joint Advisory Group (JAG) accredited.
- The hospital should speed up the implementation of the new evidence based end of life care pathway - Nursing Management Plan – Excellent Care in the Last Days of Life.

Evidence-based care and treatment

- The hospital used a combination of National Institute for Health and Care Excellence (NICE) and Royal College guidelines to guide the treatment they provided. For example, the national early warning system (NEWS) was used to assess and respond to any change in a patient's condition. This was in-line with NICE guidance CG50.
- NICE guidance was discussed at clinical governance meetings and updates were cascaded down from cancer lead nurses and clinical nurse specialists to staff at ward level.
- The oncology and end of life care ward followed best practice guidance in the care of their patients using NICE guidelines for administration of chemotherapy and stem cell transplant. Up-to-date clinical guidelines were discussed at acute oncology group meetings. This was attended by the cancer lead nurse and ensured collaborative working within oncology teams in the hospital. The outcome of the meeting was then shared across the oncology and end of life care team.
- Staff told us the Liverpool Care Pathway (LCP) was previously used by the hospital and discontinued in July 2013. The hospital had developed an evidence based end of life care tool called 'Nursing Management Plan – Excellent Care in the Last Days of Life' which they were about to roll out after the inspection.
- Staff told us the clinical policies and guidance were available on the hospital intranet. There was also a wide range of locally produced evidence based guidelines on the intranet, which were updated regularly.
- We reviewed some of the hospital policies and found they were compliant with current guidance and best practice. We noted all local guidance we reviewed had a review date on them and they were all in date.

Pain relief

- Medicines, including controlled drugs, were available to relieve pain if patients required them. Oncology patients usually brought their own medicines when attending the hospital, but the pharmacy was able to provide drugs if prescribed.
- If a patient on the oncology and end of life care ward needed a controlled drug, a nurse could access drugs kept on the ward. The ward staff also sought advice from the clinical nurse specialists on oncology and end of life care issues.
- We saw pain control medicines were recorded on the patient's drug administration charts and given when required. Pain scores were recorded in the patients' notes to demonstrate the effectiveness of pain relief and patient comfort level.
- Patients told us they had received appropriate pain relief. We observed staff assessing patients' pain levels and taking appropriate action to ensure that pain relief was administered in a timely way. Patients we spoke with confirmed they were comfortable and were happy about their pain management.
- Assessments of patients' pain were included in all routine sets of observations. As part of the "intentional rounding" process, where staff attend patients at set intervals to check a range of patient related clinical and vital signs, staff ensured that patients were comfortable, their pain well managed and recorded this in their medical notes.
- Staff told us they could access the palliative care consultant and clinical nurse specialists for support and advice on pain management, when looking after more complex patients.

Nutrition and hydration

- The assessment of nutrition and hydration support needs was one of the eight sections of the 'Nursing Management Plan – Excellent Care in the Last Days of Life'. In addition to assessing the patient's needs and taking action to address these, there was a prompt to record concerns raised by the patient or their family about nutrition and hydration and the outcome of any discussions.
- Patient records showed that fluid intake and output was monitored and recorded on fluid balance charts.
- Oncology and end of life care patients had a choice of meals for breakfast, lunch and dinner, and were offered

additional snacks in the mornings and afternoons. They could ask for meals at other times, from a more limited range of options, and change their orders if they preferred.
- Nursing staff informed us that if a patient had a special dietary requirement, the chef would visit the ward to speak to them. Menu options were available for patients who needed special diets for religious or cultural reasons.
- The chefs catered for all diets and were willing to prepare any specific foods to meet patients' preferences and needs, such as lactose intolerant, and coeliac disease as well as religious diets.

Patient outcomes

- We were told the endoscopy service did not have Joint Advisory Group (JAG) accreditation. However work was underway to upgrade the endoscopy service to meet JAG accreditation.
- There was an audit schedule in progress across the oncology and end of life care services we inspected which included record keeping and consent audits, pain control, syringe drivers. The results of these audits were reviewed at the clinical governance meeting and acute oncology group meetings, minutes of these meetings were shared with staff on the oncology and end of life care ward meeting minutes folder. A signature sheet was attached to the minutes to ensure that staff had signed the sheet to confirm they had read the minutes. We saw evidence of actions taken in response to national audits in some instances such as changes to patient records, improved monitoring procedures and improved checking procedures for patients on chemotherapy.
- The hospital took part in national audits such as the National Joint Registry (NJR) and where appropriate the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) all focusing on patient outcomes, however they didn't participate in the national care of the dying patient audit (NCDAH)
- The hospital was working with The Private Healthcare Information Network (PHIN) to improve reporting of patient outcomes across the independent sector. The information shared should improve transparency and be comparable with data supplied by the National Health Service (NHS).
- Nursing staff on the oncology and end of life care ward explained how they discussed patients who might be in the last phase of life and focused on alleviating symptoms and supporting the patient and their family.

Competent staff

- New staff to the hospital underwent a comprehensive corporate induction process which included completing competency assessments for nursing staff. Induction was tailored to the role and the needs of individual members of staff.
- Nursing staff had access to training and development opportunities to advance their professional skills, knowledge and experience to develop the services. The hospital had developed a close relationship with an NHS hospital for the provision of specialist oncology and end of life care training programme for their nurses, which trained them to develop competencies in chemotherapy and stem cell transplant.
- The hospital had a comprehensive induction system in place for all new members of staff. It included role specific training but also incorporated core elements of infection prevention and control, basic and intermediate life support and safeguarding training. Competency programmes were in place for new members of staff, the competency training included venepuncture, drug administration, intravenous infusion skills, basic life support and safeguarding among others. The programme included both a practical skills and knowledge assessment.
- Appraisal rates for oncology and end of life care ward staff from January 2015 to December 2015 was 100%. Clinical supervision was undertaken by the nursing staff regularly. Oncology nurses undertook assessment of clinical competencies before undertaking any extended role on the ward.
- The cancer lead nurse and oncology clinical nurse specialist attended regular oncology conferences and internal corporate meetings within Aspen Healthcare and disseminated information to the oncology and end of life care team.
- The Medical Advisory Committee (MAC) was responsible for granting and reviewing practising privileges for medical staff. New consultants were required to provide evidence of qualifications, training and registration. The

hospital maintained a list of consultants showing their indemnity insurance and review dates, and we noted that all the consultants had submitted appraisals as required.

- The hospital had systems in place to ensure qualified doctors and nurses' registration status had been renewed on an annual basis. There was a robust process in place to ensure doctors had undergone revalidation. Of the consultants working within the oncology and end of life care, 100% had undergone revalidation. The hospital had appropriate procedures in place to review practising privileges on an biennial basis and issues related to performance were dealt with as they arose.
- Internal rotation of nurses took place between the chemotherapy suite and the ward to ensure maintenance of skills in chemotherap.

Multidisciplinary working

- Throughout our inspection we saw evidence of good multidisciplinary working in all areas. We observed positive interaction and respectful communication between professionals. Information was appropriately shared about EOLC patients transferred home with community teams, such as GP's and district nurses.
- Our review of patient records, talking with staff and patients confirmed there was effective multidisciplinary (MDT) working practices which involved nurses, doctors, pharmacists, occupational therapists and physiotherapists.
- Nursing staff maintained good links with the local NHS trust, particularly through chemotherapy courses, oncology and end of life study days.
- The resident medical officer (RMO) attended the hospital "huddle and cuddle" handover meetings in the morning and afternoon. Consultants handed over relevant information about patients to the RMO before leaving the hospital. We saw that when needed the RMO contacted the consultants at home during out of hours.
- Patient records showed that there was routine input from nursing and medical staff and allied health professionals, such as occupational therapist, physiotherapists and dietician. There was communication between nursing and allied health professionals to support patients with pain relief, appropriate moving and handling, and arrangements for discharge.
- Staff told us they felt the hospital worked as a unit and not as individual departments. There was good communication between departments with good handover of patient information.

Seven-day services

- The hospital ward was staffed to provide nursing care seven days a week, 24 hours a day. A senior nurse and or a manager was always available at the hospital as a point of contact for staff and patients, this included helping resolve patient queries and to accept out of hours admissions, they were available via bleep or telephone.
- A resident medical officer (RMO) was based on site 24 hours a day, seven days a week. Consultants provided 24-hour on-call cover for their patients and out of hours they were contactable by phone. Consultants visited their patients daily as part of their care pathway. The nursing staff told us they had no hesitation in contacting consultants at any time to discuss their patient's condition or care.
- A radiographer was available and was contactable out of hours. There was access to a physiotherapist during out of hours and the pharmacy service was available Monday to Saturday and out of hours by telephone which ensured that patients were able to obtain their routine or discharge medication.

Access to information

- Clinical staff were able to access electronic patient records from across the hospital using a log in, which meant they were able to access current medical records. Paper records were also available.
- Nursing staff had access to computers on the wards. Patient past medical records were stored in notes and kept securely on the nurse's station/office.
- There was access to guidance, policies and information on the hospital intranet.
- We saw examples of patients being given leaflets that explained their treatment such as chemotherapy treatment regime, neutropenic sepsis and pain relief.
- Even though the hospital worked well with community GP practices, there were no information or records about GP's been informed about their patients requiring an end of life care in the community. Nursing staff informed us that they do not routinely inform GP's about their patients requiring community end of life care, however they do sent out discharge notifications to GP's with the consent of patients.

Good

Medical care

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Completed consent forms were seen in patient's record on the oncology and end of life care ward. These were clear and concise and showed consent had been obtained from the patient for planned treatment.
- We saw evidence in patient's records that staff had obtained verbal consent from the patient before invasive procedures were undertaken and this was clearly documented by the nurse carrying out the procedure.
- We reviewed seven sets of patient notes and all of them contained 'Do Not Attempt Resuscitation' (DNACPR) forms, which were accurately completed and kept in the patient's notes. There was evidence of discussion on DNACPR with patients and their families.
- Staff reported they had attended training on Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training. Staff we spoke with were aware of the requirements of their responsibilities as set out in the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS), and told us they would refer patients to the safeguarding teams if patients required a MCA and DoLS assessments.
- The hospital reported an average of 95% of nursing staff had attended Mental Capacity Act (MCA) training as part of their mandatory training and this was in line with the hospital target. However the oncology and end of life care services had 100% compliance.
- Patients told us nursing staff gained their consent before care or treatment was given. We observed a nurse obtaining verbal consent by asking a patient if they could take their blood pressure. We saw consent to treatment forms had been signed by patients prior to medical/invasive procedures. Paper copies were retained in the patient records.

Are medical care services caring?

Good

We rated caring as good because:

- Feedback from patients about their care and treatment was always positive and we observed staff being supportive and compassionate to patients.
- Patients told us they felt they had sufficient information to allow them to be involved with their care and had their wishes respected and understood.
- Patients were contacted by the hospital after they had been discharged offering help and advice if required.

Compassionate care

- Throughout our visit we observed that patients were treated with dignity and respect. We observed all levels of staff respectfully knocking on bedroom doors and waiting for a response before entering, and would introduce themselves before undertaken any duties or tasks. Patients told us they were referred to by their name of choice. We saw this was documented in their care records.
- The inpatient satisfaction survey the hospital conducted from January to December 2015 indicated 100% of patients stated they were treated with respect and dignity. The results showed patients were satisfied with the care and treatment received at the ward.
- Staff knew about the chaperone policy and notices for patients were displayed in clinical rooms.
- Patients we spoke with told us that they had received very good care and could not fault the way they had been treated. One patient told us that they had been treated compassionately, with great respect and their dignity protected.
- All patients and relatives spoke positively about the care and support they had received. For example, one patient commented "I am very pleased with the care, the sister and her nursing staff are brilliant and they made me comfortable". All the relatives we spoke with were very complimentary about the way they were treated.

Understanding and involvement of patients and those close to them

- Patients in the oncology and end of life care ward stated they were kept informed about their care, involved in any decision-making, and were listened to at all times.
- Patients told us they were kept informed and doctors and nurses discussed their care with them and their family as appropriate. Self-funded patients received information on finance arrangements.
- All the patients we spoke with, told us they had been provided with relevant information, both verbal and written, to make an informed decision about their care and treatment.

- Oncology nurses provided patients with information on discharge. They gave them information about the signs and symptoms to look out for following chemotherapy, and what they could do to relieve them. They also gave them the ward contact details in case of a worry or concern for them to contact the ward.
- Information was given to patients about their care and treatment when they first attended the hospital. All of the patients we spoke with told us they felt they had been given sufficient information before and after their admission, treatment and care at the ward.
- Patients on the oncology and end of life care ward had access to a range of literature from the Macmillan Information Centre at the Cancer Centre located near the main Parkside hospital. There was an information pack available which was specific for patient's conditions and circumstances.
- The oncology and end of life care ward had access to Arabic interpreters at the hospital, and staff could also access interpreters of other languages from outside the hospital when required.

Emotional support

- Patients commented that they had been well supported emotionally by staff. For example, in relation to side effects of chemotherapy. Patients were referred to counselling services and specialist nurses at the NHS trust if needed.
- A quiet room was available to discuss bad news with patients and relatives if this was required.
- There was a Chaplin who visited the ward once a week and could be called upon when needed. Chaplin's of different religious faiths could be requested to visit at short notice if this was necessary. However there was no multi-faith room at the hospital, the oncology and end of life care ward had a quiet room which can be used by families as a place of reflection.
- Throughout our inspection visit we observed nursing staff giving reassurance to patients and additional support given when it was required, especially if patients were apprehensive about their care and treatment at the ward.
- We were told by the nursing staff that patients were routinely contacted by the ward 48 hours after they had been discharged for further help and advice, and were also advised to contact the ward if they suspected they had an infection.

Are medical care services responsive?

Good

We rated responsive as good because:

- Services were planned to meet patients' needs. The flow of admissions and discharges through the hospital was well organised. Oncology and end of life care patients were able to access services when needed and these services were responsive to their individual patient needs.
- Patients had their needs assessed and essential care rounds were undertaken at different times of the day. Patient care was planned and one to one observation were carried out on patients on the oncology and end of life care ward. Patients who had complex needs or who were at risk of deterioration were supported during the day and night with appropriate treatments.
- Patients were aware of how to make complaint or to provide feedback about the service if needed. Complaints and concerns were taken seriously, responded to in a compassionate way, investigated in a timely manner and learning taken to improve future practice. Nursing staff were aware of learning from complaints across the hospital. There was evidence that lessons had been learnt and actions taken as a result.

Service planning and delivery to meet the needs of local people

- The oncology and end of life care ward was located on the third floor of the main hospital, and all patients rooms were ensuite with wall mounted television in each room.
- We saw examples of usual visiting hours being varied to accommodate the needs patients and visitors who were very sick. We saw examples of relatives being encouraged and supported to stay with very sick patients during our inspection visit. Relatives were provided with free meal when staying with their sick relatives.
- The endoscopy unit did not have Joint Advisory Group (JAG) accreditation. There was a project planned to re-configure the unit to meet the JAG accreditation. The limited decontamination area in the endoscopy unit,

posed an infection control risks in handling scopes, however, staff were trained to ensure that their work practices and patient pathways mitigated the risks to patient care.

- Most admissions to the ward were pre-planned so staff could assess and plan patients' care needs before treatment. This allowed staff to plan patients' care to meet their specific requirements, including cultural, linguistic, mental or physical needs. The hospital used admission criteria for patients undergoing stem cell and bone marrow transplant and only accepted patients for treatments with low risks of complication and whose post treatment care could be met through ward-based nursing care.

Access and flow

- The admission process, care pathways and treatment plans were the same for private and NHS patients.
- Endoscopy staff worked efficiently according to the patient pathway to ensure patients did not have to wait unnecessarily for their procedure. Patients were transferred to the day care area for recovery following endoscopy and when ready were discharged home or transfer to their ward where applicable.
- Our inspection did not highlight any concerns related to the admission, transfer or discharge of patients. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements. Discharge planning was initiated during admission to determine how many days patients would need on the ward as well as ascertaining whether patients were likely to require additional support at home when they were discharged.
- Patients who wanted to die at the hospital or in their own homes or other place of their choice had this documented during admission. Ward staff made every effort to transfer patients to their preferred place of death within 24 hours if all the relevant assessments and community resources were readily accessible. Sometimes patients were not discharged and transferred to their preferred place as it was not in their best interest, for example , if the home environment was not suitable to support them in, or the patient had rapidly deteriorated and it was unsafe to move them.
- Preferred place of death had only started been monitored since the beginning of the year. The cancer lead acknowledged the need to document and monitor place of death data in order to ascertain how well the service was performing against key benchmarks.

Meeting people's individual needs

- The palliative care consultant informed us that Advanced Care Planning (ACP) had been put in place for all patients in their notes and patients we spoke with confirmed that ACP was discussed with them.
- Translation services were available face to face and via a phone link system for patients whose first language was not English. In addition there was a broad range of languages spoken by a number of staff working in the hospital. Nursing staff told us they generally booked interpreters in advance; however staff told us this was rarely used as patients did not require interpreters, even if they did required an interpreter, they were encouraged to bring someone with them who could interpret for them.
- Family and friends could visit patients on the ward at any reasonable time.
- Mobility and manual handling assessments were carried out by nursing staff on the ward and where a hoist was required; this was easily accessible by staff. Call bells were accessible for patients on the ward to allow them to call for assistance if needed.
- Ward staff had support and advice from the senior nurse for people living with dementia and those with learning disability. Nursing staff recognised that end of life care patients living with dementia should be assessed early and their treatment planned to meet their needs.
- Nursing staff recognised that an individualised approach was needed to support patients living with dementia as well as those with learning disabilities when they approached the end of life.
- The oncology and end of life care ward was bright and spacious, and patients and visitors had access to drinks and patient information leaflets, however these were not available in any languages other than in English language.

Learning from complaints and concerns

- A comprehensive complaints policy was available which stated all staff working in the oncology and end of life care ward must adhere to the policy. The policy was based on national guidelines and private healthcare industry standards.

Good

Medical care

- All staff received information about the hospital complaints procedure as part of their induction. The staff we spoke with were clear on the process and procedure.
- Oncology and end of life care services did not receive any formal complaints from January to December 2015. We were given a clear explanation of how complaints were handled and the role of the frontline staff and service managers in responding to them. All staff told us they preferred to deal with issues or complaints immediately and offered a face-to-face meeting with the complainant. If they found the issue could not be dealt with in their way they supported people in making a formal complaint to the hospital management.

Are medical care services well-led?

Good

We rated well-led care as good because:

- There was a clear statement of vision and values, driven by quality, with defined objectives that staff understood. The senior management team displayed characteristics of the hospital vision and values on a daily basis.
- Cancer services were in the corporate strategy, with investment planned to expand the service by increasing bed capacity. Endoscopy unit was being led through change to configure the unit that would result in an improved service and JAG accreditation.
- Effective governance and risk management systems were in place. Staff had opportunities to raise ideas and concerns when needed, which they were confident would be addressed by their managers. All the staff we spoke with felt supported and were able to develop to improve their practice. Staff in all areas stated they were well supported by their immediate line managers.
- Managers were committed to provide high quality care and improve services and facilities for patients. All staff spoke highly of their senior management team, stating that they provided a visible and strong leadership within the hospital.
- There was an open, positive and supportive learning culture, with competent local leadership and a happy work force.
- Patients were given opportunities to provide feedback about their experiences and this was used to improve the service.

However:

- The oncology and end of life care service did not have a written strategy for the service to deliver the vision of the hospital.

Vision and strategy for this core service

- The hospital's registered manager outlined the Aspen Healthcare corporate vision, to deliver the highest quality outcomes, the best patient care and the most convenient choice for patients. The Aspen Healthcare strategic plans were shared with staff through heads of department and senior nurse meetings.
- All staff we spoke with knew about the hospital-wide vision for the future and could describe them to us. For example, staff reported the hospital was improving care for end of life patients and were in the process of implementing a new evidence based end of life care pathway. The new document was available and ready to be rolled out after the inspection.
- All nursing staff we spoke with were positive about the service they provided and believed they always put the patient first. The senior management team were able to identify strengths in service delivery and areas that were identified for further improvement.
- The oncology and end of life care service strategy to deliver the vision of the hospital had not yet been developed, however we saw evidence of actions that had been taken which the senior management team felt would support a strategy for achieving their priorities and delivering good quality care.
- We saw evidence of action plans and audits from minutes of meetings to monitor and improve the services of the oncology and end of life care at the hospital.
- Endoscopy staff were aware of the strategy for the department to improve facilities for patients and achieve JAG accreditation.

Governance, risk management and quality measurement for this core service

- There was a governance structure with committees such as infection control, medicines management and health and safety, feeding into the Medical Advisory Committee (MAC) and hospital management team.

- The clinical governance committee met bimonthly to discuss a range of governance issues across the hospital, the minutes showed evidence that discussion on findings from audits, incidents and complaints took place. The minutes of these meetings clearly identified action points or plans from any decisions reached.
- We noted that arrangements for implementing and embedding learning from incidents across the hospital were robust. Feedback from hospital-wide meetings was disseminated to ward and frontline staff.
- There was clear governance and reporting structure at the hospital and this was in line with the corporate governance framework. All meetings were structured around agenda headings of governance, quality and safety related initiatives.
- Ward managers, clinical leads and clinical nurse specialist participated in monthly heads of department meetings where matters such as operational issues, patient satisfaction, audits and training were discussed. The minutes of the meetings we reviewed identified staff were up to date with their mandatory training and evidence of shared learning from incidents was also noted.
- The Medical Advisory Committee (MAC) had a role in reviewing consultant contracts and maintaining safe practising standards amongst consultants and clinicians. Each consultant was required to complete biennial reviews with the MAC chair, during which data on their clinical performance was discussed. The hospital also ensured that all their consultants had appropriate professional indemnity insurance and received regular appraisals from their substantive NHS organisations.

Leadership and culture of service

- There were clearly defined and visible corporate leadership roles at the hospital. Senior staff provided clear leadership, motivation and encouragement to their teams. The senior management team were known to staff and were visible throughout the hospital on a daily basis talking with patients and observing clinical practice.
- Nursing staff were positive about the leadership of the oncology and end of life care ward senior management team. The leadership team was visible and approachable. For example, the lead cancer nurse and the clinical nurse specialist were actively involved in the day to day operations of the ward and they offer support to the ward manager and other staff. They were able to speak to patients and staff first hand.
- During a focus group held prior to the inspection staff unanimously told us they felt valued and respected by the hospital's managers and consultants. Many staff had worked at the hospital for many years and had family members who also worked at the hospital, this demonstrated their job satisfaction.
- The oncology and end of life care ward held monthly meetings with a standard agenda which covered business and staff issues such as staffing, staff training, complaints, incidents, and new policies.
- Consultants we spoke with were positive about senior management of the hospital and described good working relationship with their RMO's, nursing teams and other allied healthcare professionals.
- The Resident Medical Officers (RMOs) were positive about the culture and commented that all staff worked well together.
- We observed a learning culture where staff development was supported and encouraged. We saw the hospital's continuing education policy was promoted.

Public and staff engagement

- We heard many examples of how staff were engaged and informed about the hospital progress and future plans. The hospital director had a daily walk about at the hospital and spoke with staff about issues in a relaxed atmosphere. All the staff told us they thoroughly enjoyed their interaction with the director and found it beneficial.
- The senior management team told us they had an open door policy which the staff we spoke with confirmed. Staff felt they could approach any of the team with confidence that their issues or concerns would be dealt with confidentially in a respectful, compassionate way.
- Monthly staff and team meetings were held, where presentations were delivered and interactive sessions were held for staff discussions on issues affecting the ward and the department. Minutes of the meetings were kept in the staff folder at the ward.

Good

Medical care

- Patients were encouraged to provide feedback through the Friends and Family Test (FFT) and the Aspen patient satisfaction survey. Results of the latest patient survey showed a high level of patient's satisfaction, with the hospital scoring 100%.
- Staff engaged in regular informal developmental meetings with the ward management team. Nursing staff were engaged at various levels of meetings and views were shared on service development. Nursing staff told us they could discuss any issues with the management team and felt they were listened to.

Innovation, improvement and sustainability

- The hospital had a rolling programme of refurbishing the ward and approximately half of the oncology and end of life care ward had already been done.
- A dietitian with a special interest in oncology patients had recently been employed at the hospital, and sees all oncology and end of life care patients. The ward manager informed us they worked closely together with the dietician to provide holistic diet to patients on the ward.
- The dietitian had developed her own diet sheets and tools and rolled out training to staff and had worked with the catering team to develop new initiatives to meet patient needs including:

1. New "All Day" menu for patients who may not be able to eat at meal times they now have flexibility to order food from this menu at any point of the day
2. New "Small Choice" options on menu – responding to feedback from patients that portion sizes were too big
3. Specific menu for Arabic speaking patients

- Staff felt performance and loyalty was recognised, for example, staff had been successful in internal promotions.

Good

Surgery

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

Information about the service

Parkside Hospital has four operating theatres and two main surgical wards. A wide range of procedures are undertaken in the hospital on a private basis and on a limited number of NHS patients. In 2015, approximately 2300 procedures were performed at the hospital for both adults and children. These included day cases and procedures where people stayed overnight.

The ward on the first floor has 21 beds and is primarily for patients who have undergone orthopaedic surgical procedures. The ward on the second floor has 23 beds and is for patients who had undergone a broad range of surgical procedures. On the first floor, there is also a High Dependency Unit (HDU), with four regular beds and one bed in an isolation unit. When the wards are less busy, patients would occasionally be placed on the third floor medical ward.

An additional building on the hospital site called 'The Lodge' provides some of the pre-assessment services. Other pre-assessment is provided within Parkside Hospital at Putney.

On the inspection, we visited all three wards and the high dependency unit as well as the theatres and pre-assessment service. We spoke to 11 patients, relatives and friends, 37 members of staff and reviewed 17 clinical records.

Summary of findings

We rated this service as good because:

- Care and treatment were provided in a clean environment according to national standards.
- There were appropriate levels of suitably trained staff.
- Patients were treated with kindness, courtesy and respect.
- The service could be accessed easily and there were no delays to discharges.
- The service was working on updating policies to incorporate the new NICE guidelines for pre-operative assessment, and evidence based treatment was delivered by competent staff.

However:

- The service needed to actively tackle some of the issues flagged by the governance system and improve the quality of data collection of aspects of the system itself.

Good

Surgery

Are surgery services safe?

Good

Summary

We rated safe as good because:

- Care and treatment took place in a clean environment.
- Patients were appropriately risk assessed, their condition was monitored throughout their stay, and there were appropriate procedures and protocols for responding to any deteriorating condition.
- There were appropriate levels of staffing across the service on each shift.

However:

- It was not clear if all consultants were clear about the outcomes of never events and incidents.
- There were recruitment and retention issues with nursing staff, particularly the recovery suite, which placed extra pressure on staff and agency staff were frequently used.
- Improvements were needed to the anaesthetic cover of the High Dependency Unit
- Some patients did not receive a pre-assessment prior to their operation and this meant that there was a risk that a patient could deteriorate unexpectedly during or after their surgery leading to an unplanned admission to the High Dependency Unit or an emergency transfer

Detailed Findings

Incidents

- There was a policy and procedure for reporting on incidents. There was a electronic system (Datix) which was used to report incidents. These were then reviewed by senior staff and it was for the Heads of Department to disseminate any lessons learnt to junior staff. Incidents were discussed at the daily morning theatre huddle.
- Senior staff were able to describe the changes that had been made as a consequence of incidents. These included improving the pre-assessment process to ask about risk factors, improving equipment servicing and changing the booking system to prevent last minute additions to lists. Staff reported that there had been improvements in performance following these changes.
- Nursing staff were able to describe changes that had occurred to protocols and procedures as a result of the review of incidents. These related to changes in the way medicines were recorded and how patients were collected from recovery. The outcome from incidents could also be discussed and disseminated at daily ward briefings.
- In 2015, three Never Events had taken place at the hospital. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. We saw details of the events that had happened and records of the subsequent root cause analysis (RCA) investigation and appropriate actions taken to prevent their reoccurrence. The never events did not indicate any systematic issues within the service. We also saw records of other incidents that had occurred in the surgical service and actions taken to prevent their reoccurrence.
- The learning from never events was disseminated to consultants by email and personal letters. It was also discussed at theatre team meetings. However, not all consultants we spoke to were aware of the outcomes of never events and incidents.
- Some staff were able to describe never events that had taken place, and the changes that had been made as a result. They said that these were discussed at team meetings (both the daily ones and the bi-monthly ones). However, some theatre staff told us that they had not received any feedback about Never Events.
- Senior staff reported that Human Factors training had now been undertaken in direct response to a recent Never Event where it was thought that behaviour had been a significant factor. They stated that developing the cross-team relationships within theatres was a work in progress.
- Where dissemination of learning from incidents and events had not been taken amongst senior medical staff, there was a process for further escalating this to the Medical Advisory Committee.

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

- The service used a safety thermometer. This monitored their performance in terms of numbers of pressure ulcers, falls, catheter infections as well as other

important safety data. This information was collected on a monthly basis and reviewed by staff. Where there were issues, actions were taken to address them. We reviewed results from the last three months of 2015 and no significant issues were disclosed. The results were posted on the wards notice board where patients and visitors could see it.

Cleanliness, infection control and hygiene

- A nurse in theatres was the infection control lead. She undertook infection control audits on a quarterly basis.
- We reviewed the results of the most recent infection control audits undertaken. These covered appropriate areas such as infections, hand hygiene and environmental cleanliness. The results were broadly positive, though they did disclose an ongoing issue with peripheral intravenous cannulas. Staff reported to us that it was primarily about the recording of when they were placed. They said that they had taken steps to improve performance in this regard, which had not been successful, and were now escalating the issue.
- Throughout our inspection, we saw staff were bare below the elbows and followed appropriate hand hygiene protocols.
- Surgical Site Infection Surveillance Service forms were completed in theatres and questionnaires were given to patients on discharge. When these were returned, they were sent to the microbiology service for analysis and the results were reported to relevant staff.
- Theatres were cleaned between patients and at the end of each list. They were deep cleaned every six months. Suction filters were changed every four months, curtains were changed every six months. Clinical waste was taken away every lunchtime and evening.
- There was a separate scrub room in the theatre complex with an appropriate scrub trough and sink, and non-touch solution and taps.
- An external company was contracted to undertake microbiology on behalf of the service. All samples were sent to this external service for testing. This included the monitoring of all infections, including wounds, catheters and blood. The results were then reviewed by the Infection Control Committee. An external consultant microbiologist was responsible for monitoring the results to ensure no serious issues were identified. We reviewed the most recent data on this and no significant issues were disclosed.

Environment and equipment

- Throughout the wards, theatres, recovery facilities and HDU the environment was clean and tidy. We saw records of checks on cleaning which were up to date. Equipment had stickers to indicate when it had last been cleaned. There were appropriate facilities for the disposal of both clinical and non-clinical waste. Personal protective equipment, including gloves and goggles, were available. We saw staff using these appropriately when treating and caring for patients. Antiseptic hand cleansers were used throughout.
- There was an equipment and environment checklists in use in the anaesthetic department. These covered checks on vital equipment such as the anaesthetic machine, the breathing system and the suction unit, as well as whether the equipment had been cleaned and that the anaesthetic drawers were stocked with appropriate supplies.
- There were equipment and environment checklists in use in theatres for daily completion when the theatres were used. These included checks on the lights, the laminar flow, the portable suction unit, as well as environmental aspects such as humidity and temperature of the theatre itself. There were appropriate records of daily checks being made on the Automated Electronic Defibrillator and suction equipment, and weekly checks on the Malignant Hyperthermia trolley equipment and the difficult airway trolley. There were completed records of checks on the electrical safety of equipment.
- Theatre staff told us that they had access to all the equipment that they needed.
- Theatre staff had access to portable x-ray equipment, which staff told us worked well.
- The room allocated for pre-assessment was small; however it contained all necessary equipment.
- We saw completed records of daily and weekly checks on the resuscitation trolley and equipment in the recovery room and the trolleys on the wards.
- There was an external company that was responsible for maintaining all equipment, who would attend if equipment broke down. There was annual servicing of all machines and their electrical safety was tested.

Medicines

- Medicines kept on the ward and in the anaesthetic department were regularly checked to ensure that they were in date and that none had gone missing. The

temperature of fridges was checked on a regular basis and there was a thermometer to monitor the temperature of the ward environment. We saw completed records of temperature checks of fridges in the anaesthetic area.

- Controlled Drugs were checked twice a day. The controlled drugs record was kept up to date and completed correctly. Pharmacy staff had a list of staff authorised to dispense controlled drugs and did audits every six months to check this was taking place. No concerns had been raised in the most recent audit. The drugs themselves were stored securely.
- There were no set medicine rounds as all anaesthetists and surgeons prescribed drugs at different times. This had been discussed with the doctors to try and make the times easier to manage and to hopefully reduce the potential for medicine errors.
- In the records that we reviewed, the medications charts were complete and up to date.

Records

- All records were stored electronically. Staff told us that they had ready access to records.
- We reviewed 17 patient records. In general, these were complete and up to date. Entries were legible. Appropriate documentation had been completed including risk assessments, observations, consent and surgical safety checklists.

Safeguarding

- There was an e-learning course on safeguarding which staff were required to undertake. Staff were aware of how to report any concerns that they had. At the time of the inspection there had been no recent safeguarding incidents.

Mandatory training

- Staff undertook mandatory training in a range of appropriate topics. These included hand washing, infection control, moving and handling, Intermediate Life Support (including for paediatrics) and safeguarding. Junior staff told us that senior staff were very keen for this to take place and regularly sent them reminders about completing it.
- When staff logged on to the internal computer system, any new policies or updates/alerts would be automatically flagged to them, and staff had to open and read the policy to annul the flag. During the inspection policies that had been flagged included the CPR policy and the complaints policy.
- Senior staff reported that the majority of staff were up to date with their mandatory training.

Assessing and responding to patient risk

- On arrival at Parkside Hospital a range of risk assessments would be completed. These included risks such as falls, nutrition and blood clots.
- It was the responsibility of consultants, anaesthetists and nursing staff to be observant of signs of a patient deteriorating. If they began to deteriorate whilst on a ward, the Resident Medical Officer (RMO) would then take the lead in caring for them. Then RMO would then call staff in the HDU if necessary who would attend and help transfer the patient there if needed. Early Warning Scores, used to spot signs of a deteriorating patient, were used throughout the service. HDU staff were used to train staff in how to use these. The use of Early Warning Scores was audited on a regular basis, though it was noted that the results of this indicated they were not always recorded accurately. This was confirmed in our own review of records.
- Intentional Rounding forms were used on the wards to monitor whether patients' essential care needs were being met. These were completed hourly during the day and every two hours at night. They included details about the patient's position, pain and elimination. We checked two sets of notes and saw that these had been completed accurately.
- All patient rooms had emergency call bells which were tested daily. The majority of patients that we spoke with said that staff answered call bells promptly when they were used.
- The HDU only treated levels one and two patients. Where there was an anticipated need for level three critical care treatment, these procedures would not take place at Parkside Hospital.
- Staff said they needed a dedicated anaesthetic cover for the HDU unit and were trying to arrange a rota for this at a nearby acute trust at the moment. This was needed, as at the moment, there could be up to four different anaesthetists with patients in the HDU, and they could also be busy with patients further down their lists. There was a protocol for whom to contact for extra support in such circumstances.

- Hospital policy was for patients to have a face to face pre-admission assessment, if they were undergoing procedures that needed admission to the hospital. Day case patient pre-assessment interviews could be carried out with a telephone call, but if significant issues were highlighted, this would be changed to a face to face assessment. This assessment would identify any risks to the patient based on their medical history, whether these risks could be minimised and if the hospital could safely care for them. All referrals were screened; patients who had conditions such as unstable diabetes or high blood pressure had, their procedures delayed until the issue was resolved. We spoke to a patient who confirmed that their procedure had been delayed until they had been treated for a condition found during this assessment.
- However, we found that some patients refused to attend a pre-assessment or had a more limited range of tests done, due to a short lead time for the procedure. In one case, a patient's procedure was carried out, without knowledge of pre-existing medical conditions. This led to an unplanned admission to the High Dependency Unit (HDU). A new policy was being drafted for pre-assessment that would set a minimum time between the decision for surgery and the procedure that would reduce the risk of this happening and we saw a copy of the draft policy.
- Incidents that had led to unplanned admissions to the HDU or an emergency transfer out of the hospital were not fed back to the pre-assessment team, making it difficult for them to adapt their procedures if required.
- Staff that we spoke with said that the RMO would attend promptly when called. There was provision for the RMO to be replaced at short notice if they felt too tired to continue their shift. Face to face handovers took place between RMOs to ensure that all relevant risk information about patients was passed on.
- There was a procedure for when patients became critically unwell. They would be transferred to local NHS hospitals by the ambulance Service. The service held a service level agreement with a local acute NHS trust to receive emergency patients requiring a higher level of care. Appropriate staff, including the senior nurse and anaesthetist would accompany the patient to the hospital. The anaesthetist held overall responsibility for this.
- The 'five steps to safer surgery' checklist is a process that involves a number of safety checks before, during and after surgery to avoid errors. Theatre staff told us that the completion of the safer surgery checklist was "embedded" within the culture of the theatre team. However, we looked at results of recent audits of the completion of the surgical safety checklists over the past 12 months. This showed variable completion rates as high as 100% but dropping as low as 78% at one point, though the performance was variable rather than indicating a specific upward or downwards trend.

Nursing staffing

- Staff used an acuity tool to calculate how many nurses were needed on any given day. This would vary according to the number of patients and their particular needs. Throughout the inspection (including the unannounced evening inspection), we observed that these staffing levels were being met.
- Staffing of the HDU was based upon levels set out in the Intensive Care Society Core Standards for Intensive Care Units.
- When there were nursing vacancies or absences, the service filled these gaps with agency staff. Staff reported that the majority of agency staff had significant experience of working in the service.
- All the staff that we spoke with were happy with the current nursing staffing levels in theatres, wards and the HDU. They felt that there were appropriate numbers and skill mix for the patients that were being treated and that this was the case at nights and weekends as well.
- However, staff noted that there were ongoing problems with recruitment, had previously been problems with retention, and that at times this had resulted in large numbers of agency staff being used on wards. The high numbers of agency staff on night shifts had been particularly noted. Nursing staff noted that their duties would increase when new agency staff started as they had to be inducted to the ward and supervised.
- In addition, it was noted that there were ongoing nursing vacancies within the recovery suite. Whilst the agency staff who work there, do so regularly, there were only two members of staff available to be on call, which meant they worked three or four on-call shifts per week which put significant pressure on staff.
- Patients told us there were enough staff on the wards.
- Senior staff reported that they were trying to address their recruitment and retention issues by increasing the period of notice that people had to give as well as the training opportunities available.

- Nurses reported that handovers took place at the changeover between shifts which everyone on duty attended. They covered relevant safety aspects such as patient pain and comfort levels, which medicines were due and observations made.

Surgical staffing

- Surgical staffing levels were based on the number of patients on that day's lists and the procedures they were going to undertake. Consultants were required to be available for suitable follow-up with patients and to be contactable whilst the patient was still in hospital. If they were not going to be available, they had to arrange for their own cover.
- The ward staff said they could contact consultants about patients' condition following procedures, including at nights and weekends.
- Two contact numbers were taken for all consultants and anaesthetists.
- Resident Medical Officers handed directly over to their replacement at the end of their shift.

Major incident awareness and training

- If there was a fire on the ward, the procedure was to find out where it was, segregate that area and move patients (on the same floor). All doors within the wards were fire doors. The fire brigade would be called by staff if necessary. Evacuation drills took place twice a year.

Are surgery services effective?

Good

Summary

We rated effective as good because:

- Care and treatment were provided according to recognised guidelines and protocols.
- Staff were appropriately appraised, received training suitable to their role and worked well within their teams and with other colleagues.
- Pain relief was appropriately managed.

However:

- Awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards was limited amongst some staff groups.

Detailed Findings

Evidence-based care and treatment

- There were clear high dependency unit (HDU) admission criteria based on the Intensive Care Society Levels of Care for Adult Patients (2009).
- Within the HDU, the Association of Anaesthetists for Great Britain and Ireland protocols on the management of sever local anaesthetic toxicity were used, as were the ABCDE guidelines for assessing adults. There were protocols available for treating tachycardia algorithm, cardiac arrest and allergic reactions. The European Resuscitation Council guidelines for adults and children were also followed. The majority of their protocols were contained in the Intensive Care Council's Guidelines for the Provision of Intensive Care Services.
- Surgical staff followed national guidelines when undertaking procedures. Examples included the British Orthopaedic Association guidelines on Total Knee Replacements, but each consultant would have their own preference for which surgical guidelines to follow and these were not prescribed by the service.
- Staff were aware of the recently published guidance on cosmetic surgery but, at the time of the inspection, no new protocols had been put in place.
- Updates about NICE protocols were provided via the staff intranet system.
- The NICE algorithm for IV fluid therapy was used.
- The service submitted data to the National Joint Registry about the joint replacement procedures undertaken. We reviewed their most recent results which were broadly positive.
- The hospital had recently started submitting Patient Reported Outcome Measures PROMS data for private patients (and NHS) for the following procedures: Cataracts; Total hip replacements; Total knee replacement and Inguinal hernias. However data was not currently available to CQC due to data time lag and poor completion rates.

Pain relief

- Anaesthetists were responsible for pain management immediately after procedures and then the consultant would take over from them afterwards.
- Pain scores of zero to three were used with zero being no pain and three being most pain. The nurses that we spoke with confirmed that most anaesthetists wrote up

appropriate post-operative pain relief medication prescriptions. They said that they rarely had to call them for pain management reasons. If a patient's pain was escalating they would call the RMO.
- Patients that we spoke with said that they had adequate pain relief.
- Within HDU, patient controlled analgesia pumps were used to manage pain.
- In the most recent patient feedback survey from quarter one of 2016, patients rated the way their pain was managed positively with 93% saying it was well managed.

Nutrition and hydration

- The service had a dietician (though they primarily worked on the oncology ward under the medical directorate). Nutritional assessments had been recently introduced on the wards which staff had been trained to complete. The protocol was for the re-assessment to take place if a patient stayed over seven days. Patients with high risk assessment scores were to be referred to the dietician. Staff had access to nutritional supplements and products if they needed them.
- All early admission surgical patients were 'nil by mouth' from midnight the night before their procedure. Patients who were later on the morning list were given sips of water to ensure that they remained hydrated.
- The service was currently thinking about nutritional high protein drinks being used pre-operatively, as this had been shown to help with post-operative healing.

Patient outcomes

- The service had just started collecting Patient Reported Outcome Measures (PROMS) to help monitor the quality of their treatment outcomes, but at the time of the inspection, the first reviewed set of data had not been received.
- Between January 2015 and March 2016, only two patients had been readmitted within 48 hours, and only six had become critically unwell and needed to be transferred to another hospital.

Competent staff

- When staff first started working at the service they were given an induction. This varied for the different areas in which they would be working but included policies on the department, daily checks to be undertaken and checks on emergency equipment's used in theatres and on the wards.
- There was a specific induction checklist for use with agency staff to ensure that they knew the basics about providing safe care and treatment to patients on the wards.
- Senior sisters undertook the appraisals of junior nurses and porters. They received training on how to appraise people. Nurses had six hours of study time each month where possible. There were procedures and protocols in place to ensure that the nurses were prepared for their Nursing and Midwifery Council (NMC) revalidation. Whilst the data available indicated appraisal rates were low, the staff we spoke with assured us they had had appraisals and senior staff reported that their official appraisal data was not accurate.
- Nursing staff were able to describe extra training courses that they had undertaken whilst working at Parkside. These included training in recovery nursing and pre and post-anaesthesia care.
- Nursing staff had been given extra training in gender reassignment care and treatment which was an increasing aspect of the service's workload. This had included the observation of the procedure, in depth talks around post-operative care and risks. The lead nurse for these procedures was developing nursing competencies around the treatment pathway to ensure staff were properly trained.
- Junior staff we spoke with described a positive working environment where they were encouraged to learn and all staff were approachable. They were given an induction, had training in the basics but were also undertaking further training in specialist topics where appropriate, such as in gender reassignment.

Multidisciplinary working

- We observed an afternoon 'huddle' on one of the wards. This was attended by staff from across the service including nursing, pharmacy, managerial, HDU and hotel services. Topics covered included which patients were staying overnight, planned workload for the weekend and actions taken to rectify minor issues with the hospital environment.
- We observed the morning 'Safety Huddle'. This featured staff from across the hospital representing all departments including theatres, pharmacy, allied health professionals, nursing, governance and facilities. This

covered relevant information about safety and performance across the hospital including which areas were operational, where patients would be staying overnight, agency levels and any facilities issues.
- Briefs and debriefs took place before and after lists featuring all theatre staff. We saw records of this taking place. At the briefing staff went through the list for the day and discussed any possible safety issues. Any safety issues that had arisen, were discussed and recorded during the debrief session. Staff described these as "helpful".
- There was a 'Theatre Users' committee which met quarterly. Members from a variety of surgical specialities attended. Topics discussed at this meeting included pain management, training and surgical pre-assessment.
- Physiotherapists were available throughout the service to provide care, treatment and support to patients and would visit patients twice a day. Hydrotherapy and cryotherapy were also available.
- The pre-assessment team told us how, for a patient undergoing a joint replacement, they would arrange the pre-assessment appointment to include an occupational therapist and a ward physiotherapist to explain the procedure and assist in recovery after the procedure.

Seven-day services

- All procedures at the service were elective and staffing and facilities were made available across the whole week as planned and appropriate to the procedures being undertaken.
- There was an on call radiologist and radiographer each weekend. X-ray, ultrasound and CT were available throughout, with mammography also available on Saturday mornings.

Access to information

- All clinical staff across the service had access to patient records and information as appropriate.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Junior staff had some awareness of what to do if a patient appeared disorientated. They said that they would try and assist them and call for the sister in charge to help. However, overall the knowledge of capacity and consent issues amongst junior staff was limited and it was not clear how readily they would recognise potential issues and where further assessment was needed.
- There were e-learning courses available on the Mental Capacity Act, Consent and Deprivation of Liberty Safeguards.
- Staff reported that they had very few patients with dementia or cognitive impairment and when they were admitted, they often did so with a carer.

Are surgery services caring?

Good

Summary

We rated caring as good because:

- Patients were very positive about the staff that care for them describing them as very kind and helpful.
- Patients were fully informed about the care and treatment they received and how to care for themselves afterwards.
- The service was rated very positively in patient feedback provided.

Detailed Findings

Compassionate care

- The people that we spoke with described staff as "wonderful" and said that their care had been "perfect". They said that staff were very caring and that their privacy and dignity had been maintained throughout their stay and that they always knock on the door before they entered people's rooms. They said that staff had 'gone the extra mile' for them.
- There were extra beds available that could be used to allow a friend or relative to stay in the same room as someone receiving treatment in order to support them.
- In the most recent patient feedback survey from quarter one of 2016, 99% of respondents said they were treated with consideration and courtesy by their consultant and 96% rated the individual attention they were given by nurses very highly.

Good

Surgery

Understanding and involvement of patients and those close to them

- Patients, friends and relatives we spoke with, said that post-operative care and support had been fully explained to them. They said the details of their procedure had been explained to them, with one patient saying that they had watched a video of what it would involve. The majority of patients said they or their relative had seen their care plans and were able to describe the next steps in their care and treatment.
- In the most recent patient feedback survey from quarter one of 2016, 100% of respondents said the risks and benefits of their procedure were explained to them by their consultant beforehand. 97% said that they received appropriate post-operative information and got answers they could understand to their questions from their consultant.
- In the patients feedback survey, 95% of respondents said the nurses explained what would be done before giving any care or treatment and 93% said that if they had important questions to ask their nurse, they got responses they could understand.
- All patients had a named nurse.

Emotional support

- One of the patients we spoke with told us of the psychological support they had been provided with by staff who they described as very kind.
- There were no restrictions on the ward for when family and friends could visit.
- There was an in-house chaplain and access to other religious persons if people needed spiritual support, who was available to conduct a daily ward round.
- We were told how pre-assessment for breast operations were now undertaken jointly with the breast-care nurses as they were able to provide better support for patients who were preparing for this procedure.

Are surgery services responsive?

Good

Summary

We rated responsive as good because:

- Beds could be readily accessed and discharges home were not delayed.
- There were facilities available for people from different cultural backgrounds and for whom their first language was not English.
- Patients were able to feedback and make complaints which staff acted on.

Detailed Findings

Service planning and delivery to meet the needs of local people

- All procedures that took place at the hospital were elective and predominantly carried out on a private basis. A limited number were carried out under NHS contract. The hospital set-up and facilities were specifically designed to meet the needs of these elective patients.

Access and flow

- There were no reported issues with the availability of beds at the hospital or delayed discharges. Consultants were required to give five days' notice before adding a patient to a theatre list.
- The pre-assessment team showed us their clinical assessment investigation table that provided a Red, Amber, and Green (RAG) rated approach to the type of assessment and investigations a patient would require. This was based on the American Association of Anaesthesiologists (ASA) physical status classification system that describes fitness to undergo and anaesthetic as well as reviewing the level of surgery that was planned. This enabled the team to plan the length of appointment effectively
- When patients were pre-assessed, they were made aware of how long they would be staying. Physiotherapy and occupational therapy referrals and orthopaedic equipment orders were done pre-operatively to ensure that these did not delay discharge.
- Staff told us there were rarely delays in theatres, and if there were, these were usually due to complications during a procedure. However, they said that these delays were usually handled well without undue negative impact on the service as a whole.
- The first floor ward would be occasionally shut down and patients transferred to the third floor medical ward when there were not enough patients to warrant keeping it open. There were procedures in place to ensure that staff with surgical training and experience were working on the third floor medical ward when this happened.

Good

Surgery

- We looked at records of recent cancelled procedures. These indicated low rates of procedures being cancelled because of issues within the service, and the majority of operations were cancelled either through patient choice or on medical advice.

Meeting people's individual needs

- There was an 'International Patient Coordinator' for overseas patients. For patients whose first language was not English, there was a process for all documentation to be translated into their language of choice and have access to interpreters when required. The international patient coordinator was an Arabic speaking person, and was used by the hospital as an Arabic interpreter.
- The service had an in-house chaplain who would do a daily ward round to see patients who wanted to see him. The chaplain retained a contact list of Imams and Rabbis and other religious persons, who could be accessed if people wanted to see them. Whilst there was no dedicated religious space, there were quiet areas of the hospital that could be used.
- Halal food was available.
- The people we spoke with praised the quality of the food available.

Learning from complaints and concerns

- There was a complaints policy and procedure. Details of how to complain were made available to patients in the 'Patient Guide' they received during the pre-admission process.
- We saw details of the complaints that had been made about the surgical service between January 2015 and December 2015. The number of complaints was moderate and no themes or significant issues were disclosed. There were records of each complaint being considered and the outcome.
- Staff told us they were aware of when there had been complaints made that had implications for them and were aware of the lessons to be learnt. They said that where they did have verbal complaints, they tried to diffuse them as and when they came up. If they were not able to do so, they would provide them with the address for written complaints.

Are surgery services well-led?

Requires improvement

Summary

We rated well-led as requires improvement because:

- There were quality issues within the service which had been flagged for a substantial period of time by the service's governance, but at the time of the inspection, they had not been resolved and a clear plan for doing so was not apparent.
- Aspects of the governance system, including the training and workforce activity data, did not provide accurate information and this had to be collected manually which hampered the service's ability to monitor these aspects.

However:

- Staff spoke positively of the open culture within the service and said that senior staff would act on their feedback.
- The service actively engaged individual patients and acted on their feedback.

Detailed Findings

Vision and strategy for this core service

- Senior staff we spoke with were able to tell us how the management were looking to develop the service in the coming years, including the views of the provider organisation. This included possibly expanding the service.
- Junior staff had some knowledge of the values of the organisation. They talked about the importance of acting with integrity and patient safety.
- There were currently changes being made within the surgical services to try and distribute some of the roles of the senior nurses to individual team leaders to help build their skills in anticipation of future vacancies in the more senior nursing positions. There was also greater investment being made into the admissions team so that they could take on further roles around bed management and dealing with insurance companies, so that ward staff could be more 'hands-on' and visible on the wards.

- Staff were positive about recent senior appointments, which they felt had improved the vision for the service. There was now more drive behind making improvements to the service.

Governance, risk management and quality measurement for this core service

- The main risks within the surgical service were recorded on the department's risk register.
- We looked at the results of audits that had taken place between January 2015 and April 2016 into significant aspects of the service including use of early warning scores, obtaining consent and use of the surgical safety checklists. Whilst this showed an appropriate coverage of audit topics and a generally positive performance, it did show poor performance in some areas which had persisted throughout the year. These included incidents, aspects of risk assessment and vacancies. We spoke to senior staff about this who confirmed that they were aware of these ongoing issues and had tried to improve performance, but the issues remained (though they did note there were some issue with the accuracy of their audit data). Some of the issues had persisted for over nine months. They also noted a marked drop in their performance scores approximately a year previously, but said that this was to do with new appointments and improved accuracy of data collection.
- Senior staff reported that they were generally happy with the level and range of issues covered by their governance systems. They reported that they had recently increased their governance to start looking at patient outcomes for procedures (though no information had come back on this yet).
- Senior staff noted that the mandatory training recording system was not showing accurate data and that they had to manually record this information to build an accurate picture of compliance with this. This was inefficient and time consuming. It was reported that the same applied to their human resources data around staffing levels and activity.
- The service also undertook Patient Led Assessments of the Care Environment audits (PLACE) in 2015 and compared its results with other private providers. This covered patient views on numerous aspects of care and treatment including protecting privacy and dignity, food, cleanliness and quality of the environment. Parkside Hospital's results were positive in all categories.
- Staff we spoke with said they got feedback on the outcome of audits and what changes needed to be made.
- The operating department was accredited by the Association for Perioperative Practice. This required the department to meet stringent criteria around the quality of the educational material available to staff.

Leadership / culture of service

- People were generally positive about the senior leadership at the service. They said they were accessible and would act on issues brought to them.
- Staff told us they enjoyed working at Parkside and felt supported by their employers.
- Junior staff told us they felt empowered to challenge more senior staff where appropriate and that managers would support them in doing so. They said senior managers were visible and approachable.

Public and staff engagement

- Senior staff were able to provide examples of where they had made changes based on feedback from individual patients. These included improving the décor and reducing meal portion sizes for patients post-surgery.
- Staff described a very personal approach to interacting with patients and listening to their needs. Patient feedback was actively sought, benchmarked against other locations and other providers, and acted on.The pre-assessment team spoke of the support they had received from the director of nursing and clinical services and said they were comfortable with raising issues through her when required.Pre-assessment staff spoke of recently started nursing seminars where they had presented information about their service, which allowed for greater understanding of the work of other departments.
- The pre-assessment team were involved in making changes to the new care pathway booklets and drafting the new policy for the hospital.

Innovation, improvement and sustainability

- Senior staff said they were confident they could accommodate innovative ideas in their practice. They reported that they had recently expanded their surgical provision to include 'designer knee' replacement procedures.

Good

Outpatients and diagnostic imaging

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

Information about the service

Parkside Hospital provides private outpatients and diagnostic services from a purpose built Outpatients Department at the hospital site in Wimbledon.

The hospital provides outpatient appointments, and diagnostic imaging for multiple specialties. Appointments are offered between 8am to 8pm, Monday to Friday and 8:30am to 1:30pm on a Saturday, although this is dependent on the clinic required.

Parkside Hospital provides elective surgery for children and young people over the age of three years. Children are seen in outpatients from birth to 18 years old. Physiotherapy is provided to children over the age of eight years old and diagnostic imaging is also provided to children. Children and young people made up 9% of the patients attending the hospital during 2015, and a significant majority of these attendances of children and young people are within the outpatient service.

The main outpatients and diagnostic imaging department has three floors accessible by lift and stairs and consists of 21 consulting rooms, four treatment rooms, a plaster room, an ophthalmic suite, a pharmacy, two phlebotomy rooms and a diagnostic imaging suite, that can provide X-ray, Ultrasound, extremity MRI Scanning and Mammography. Nuclear medicine is provided from the adjacent sister-site at the Cancer Centre London. There are waiting areas on each floor with a separate waiting area on the ground floor for children and young people. An additional building on the Wimbledon hospital site called 'The Lodge' provides physiotherapy and pre-assessment services and has a rehabilitation gym, five cubicles within a treatment area, an outdoor Astroturf area, one consulting room and a hydrotherapy pool. Patients can self-refer, referred by their General Practitioner (GP) or through consultant's private practice. NHS services are commissioned by local clinical commissioning groups (CCGs).

Staffing at Parkside Hospital consists of 19 nurses and nursing assistants, 11 physiotherapists, four physio assistants,1 occupational therapist, 20 radiographers and six clinical imaging assistants and administrative staff. Over 300 consultants have practicing privileges to carry out consultations.

As part of our inspection we spoke with 15 patients and 21 members of staff including consultants, nurses, senior managers and administration staff.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated outpatients and diagnostic imaging as 'Good' because:

- There were systems to protect patients from avoidable harm and abuse. Staff knew how to report incidents and lessons learned from these incidents were shared within teams.
- All patient areas were visibly clean, infection prevention and control processes were in place and equipment had been checked regularly.
- Staff completed mandatory training courses with good compliance rates and staffing levels were appropriate to meet the needs of patients.
- Staff providing care to children and young people had received annual training in paediatric competencies and there were appropriate plans if the condition of a child deteriorated whilst they were at the hospital..
- We observed effective multi-disciplinary working and saw that consent documentation was being closely monitored with improvements made to compliance levels.
- Patients were very positive about the care that they received and the information provided to them.
- Patients were treated with dignity and respect while they attended the hospital.
- Staff were enthusiastic about the service they provide and we observed positive interactions between staff and patients.
- Waiting times for outpatient appointments were within the national guidelines, with minimal waiting times in some specialties.
- Patients' needs were met through the way services were organised and delivered, such as providing a longer appointment time for patients with additional needs.
- The leadership of the service was good. Local and senior leadership was visible and there was appropriate management of quality, governance and risk. Staff were proud to work for the service.

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good because:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- There was an effective process for the investigation of serious incidents and a good understanding and use of the Duty of Candour (meaning staff should act in an open and transparent way in relation to care and treatment provided). Staff told us they would apologise and inform the patients or their carers if incidents occurred.
- Medicines were managed and stored safely.
- All areas we inspected were visibly clean and uncluttered.
- Staffing levels were sufficient to meet the needs of patients.
- Staff had received up-to-date relevant mandatory training which was relevant to their role, this included level three safeguarding children's training.
- Staff checked emergency equipment daily.

Incidents

- All staff we spoke with knew how to report incidents through the hospital's computer based reporting system (Datix). They were aware of the types of incidents that they needed to escalate and told us they were encouraged to report incidents.
- All incidents reported in outpatients were reviewed and investigated by the outpatients manager based at Parkside Hospital. The manager or senior outpatients nurse would share findings from incidents with individual staff and also share at team meetings and a department daily meeting (which was known locally as a huddle) at the start of each day. The manager of outpatients also explained that information from incidents was shared in emails and in newsletters. We saw a copy of a newsletter on the wall in the staff room.

Good

Outpatients and diagnostic imaging

- Incidents in the diagnostics department were discussed at the team monthly meetings for learning. A recent example of learning was that staff all now use 'pause and check' following an incident where the incorrect test had been carried out in another Aspen Healthcare hospital.
- The hospital had a contract with a member of staff at a local NHS hospital to work as the Radiation Protection Advisor (RPA) (a specialist in radiation safety and compliance matters which relevant organisations must have by law). We saw records of radiation incidents that had been reported to the RPA for further investigation.
- Incidents across different departments in the hospital were also discussed at a daily hospital huddle and a 'Sisters' meeting and any relevant feedback would then be passed onto the teams.
- Incidents relating to children and young people were reviewed at the paediatric working group and learning cascaded to all relevant departments. We saw minutes of these meetings where incidents had been discussed.
- One significant event had been reported in January 2015, where a nasoendoscope was reused in the department. A root cause analysis had been undertaken and an action plan had been completed, including a new process around disposal of endoscopes. We observed two staff members following the new process that had been set up following this incident and also saw two posters within the sluice to remind staff of this procedure.
- Staff were familiar with the term 'duty of candour'. Staff told us they would apologise and inform the patients or their carer if an incident of avoidable harm occurred. An example was given of when this had been undertaken for a significant event that had happened in January 2015.
- A duty of candour flow chart was available in the radiology department and all staff we spoke to were aware of it and what it meant.

Cleanliness, infection control and hygiene

- All areas of outpatients and diagnostic imaging that we visited were visibly clean, tidy and free from clutter. We were informed that a cleaning company cleaned the area daily, prior to the department opening and that audits were carried out for infection, prevention and control as well as a monthly deep cleans.
- The monthly deep clean checklist showed that each month, each room was thoroughly cleaned and restocked, including sharps bins, and equipment within the room.
- We reviewed results of local quarterly audit reports that had been undertaken by the hospital and found that results from April 2015 to present showed that outpatients and radiology had all performed consistently above 95% for cleanliness audits of environment and clinical practice. However, physiotherapy had a lower level of compliance overall with the lowest level of 78% recorded for quarter one of 2016.
- All clinic rooms had working facilities for handwashing, with enough paper towels and protective clothing available to use when necessary.
- We reviewed the results of the quarterly audits undertaken by the hospital for adherence to hand hygiene and found that for outpatients and radiography the scores were consistently higher than 96% ,with one exception result of 80% in radiography. Although the physiotherapy results had been between 79% and 87% up to quarter three 2015, for the most recent quarters they had 100% for their hand hygiene results.
- Personal protective equipment, such as gloves was available for staff in all clinical areas to ensure their safety and reduce risks of cross infection when performing procedures.
- Domestic and clinical waste was disposed of correctly. We saw appropriate facilities for disposal of clinical waste and sharps such as needles located in the consultation and treatment rooms.
- Staff adhered to 'bare below the elbow' guidance when required whilst delivering care.
- Equipment was well-maintained and was visibly clean and we saw 'I am clean' stickers that staff used to identify that the item had been cleaned.

Good

Outpatients and diagnostic imaging

Environment and equipment

- The purpose built building housing the main outpatients and diagnostic imaging department was well-maintained. Consulting rooms were of a good size, well lit, free from clutter and provided a suitable environment for treating patients.
- Access to store rooms was via a swipe card system and meant that they were secure.
- The lodge building housed a pre-assessment room, physiotherapy department and the hydrotherapy pool..
- There was a room that contained five treatment cubicles and also an office space for the physiotherapy team. We were told that patients would complain about the noise in the room when all the cubicles were being used and the close confines could also impact on patient's privacy and dignity. This was raised on the hospital risk register with a plan for a space review to improve the situation to be drawn up. The planned closure date on the risk register passed at the time of our inspection and staff we spoke to were not aware whether a plan had yet been finalised.
- The gym area within the physiotherapy department contained an appropriate selection of equipment, which was clean and well-maintained. There was one treatment cubicle in the corner of the gym area. This meant that if there was a patient being treated within that area and a patient was simultaneously using the gym, then the privacy of either patient could be compromised.
- Equipment was well-maintained in all departments, with stickers showing that appropriate safety checks had been completed within the last 12 months.
- Single use, sterile instruments were used where possible. The single use instruments we saw were all within their expiry dates.
- The store room where consumables were stored was clean and laid out with easy access to all equipment. On the day of our inspection, we checked 20 items of equipment at random and found them all to be within their use by dates.
- Staff told us they always had access to equipment and instruments they needed to meet patients' needs.
- Emergency resuscitation equipment, for adults and children was available in both the outpatients building and physiotherapy department, and was inspected and checked that they were sealed on a daily basis by staff. Once a week, the seal was broken and all equipment thoroughly inspected. We saw documentation to show this had been completed, although there were some areas of the check sheet not completed for one date; however all other dates were completed.
- Children receiving day surgery procedures were accommodated on the second floor of the hospital. A separate area was available in the recovery area for children and specific areas on the ward were allocated for them to recover in. A resuscitation trolley, containing paediatric equipment was available on the second floor and was checked daily.

Medicines

- Treatment rooms were clean and tidy, with keys to the drug cupboards held by registered nurses. There were separate cupboards for flammable medicines, internal and external medicines and regular medicines.
- Bulk fluids were not stored in the treatment rooms. However, these were stored in the main pharmacy (if needed).
- Fridge temperatures were recorded daily and were found to be within the recommended range. When asked what would happen if the normal fridge temperature of 2-8 degrees went out of range, the nurse stated that a member of clinical staff would be responsible for taking the appropriate action to rectify the anomaly, which included contacting the pharmacist and estates management.
- There was a policy to support the use of Patient Group Directions (PGDs), and we saw evidence these PGDs were signed by authorised personnel, in date and appropriately audited.
- Healthcare assistants were able to administer certain medicines such as emla cream (an anaesthetic cream), through an administration order after training and competency assessments had been completed.
- Emergency medicines were available, accessible for immediate use, in date and tamper-proof.
- There was a dedicated outpatient's pharmacy service available between 8.30am – 6pm, Mondays to Fridays.

They were responsible for screening prescriptions, checking medicines history, ordering and topping up of medicines and counselling patients on specific medicines usage. In addition, the pharmacist monitored the use of unlicensed medicines given to patients by writing down details such as the batch number and expiry dates of the relevant medicines. Furthermore, there were specific protocols to cover the use of each unlicensed medicine prescribed. Nursing staff stated they were happy with the pharmacy service received out of hours (evenings and weekends).They commended the support and advice received by the on-call pharmacist and main pharmacy when the outpatients pharmacy was closed.

- Staff had access to British National Formulary publications (BNFs) as well as all policies and information relating to medicines management (including the antimicrobial formulary).
- We found that staff competencies for continuous medicines management training updates were done by the provider. However, we found that this was done on an ad-hoc basis, depending on the individual needs of nursing staff (and not in a formalised regular process).
- Staff understood and demonstrated how to report medicines safety incidents. Any incident was then escalated and fed back for learning through regular meetings with the pharmacy team in charge of medicines management/ drug safety.
- We found that allergies were not always recorded on the private prescriptions given to patients. Although the pharmacy in outpatients screened for these and this was a fail-safe mechanism, there was a small risk that patients could obtain their medicines elsewhere and not be asked about their allergies.

Records

- Records used in the outpatient department were a mixture of paper based and electronic information that included test results, reports and images. Some medical notes were not held electronically. Consultants holding electronic private patient records were required to register as Data Controllers with the Information Commissioner's Office.
- The hospital policy was that a complete set of medical records must be maintained within the hospital for each of the consultant's patients. The practicing privileges policy required consultants to ensure staff had access to medical records of all of the patients treated at the hospital at all times.
- The only records that were stored within the outpatient's department were for the general practitioner service. Consultants of other specialties would bring the notes required for each day's clinic and their private secretary would collect these afterwards.
- Staff reported that records were usually available in a timely manner for clinic appointments; however, this was not routinely monitored.
- We were told NHS patients always had records available and should a referral letter not be available at the time of appointment, the outpatient reception staff would contact the bookings department or the consultant's medical secretary to obtain the referral letter. If the referral letter had not arrived, outpatient staff would contact the GP practice and ask for this to be faxed through prior to the patient being seen by the consultant.
- Referrals to the outpatients department were sent to a secure fax by the patient's GP. We were told that sometimes this was sent to the main hospital reception, which could mean a delay in receiving information and to staff in other departments having access to patient information.
- GP referral letters were then attached to the appointment electronically.
- We were told a new electronic record system was due to be implemented at a future date that would make management of patient records easier. Staff told us the current process could lead to multiple copies of notes as patients were seen at different sites by consultants and this was recognised as a risk. This had been raised at the Medical Advisory Committee (MAC), where it was documented within the minutes, that there was a working party in progress regarding patient notes.
- Each time a patient attended the outpatients department, they completed a registration form to change any personal details. This ensured that all contact details for patients held were up to date.
- All patients referred for an X-Ray would have a request form completed by the consultant. This meant that all

patients would have a form prior to receiving an X ray. We saw an audit undertaken in March 2016 on 18 forms to check compliance with this, that showed that 100% had the clinical details documented, the body part indicated and the referrer signature. However, 50% of these did not have pregnancy status indicated. An action was in place for the radiographers to check pregnancy status prior to undertaking an X ray.

- All patient records for the radiology department were scanned and kept on an electronic information system.
- Records for physiotherapy patients were stored securely in the physiotherapy department and access was restricted to staff only.
- We were told that a patient notes audit was completed regularly in physiotherapy and this had changed practice to ensure that when the notes were not written at the same time asof the appointment, this was documented in the patient's record.and the notes written time was recorded separately.
- We looked at two sets of patient records for physiotherapy and found them to be legible, with clear treatment plans and verbal consent documented for each episode of care.
- We saw the results of the imaging safety checklist audit that had been completed in April 2016. Ten records had been audited and there was 87% compliance with the requirements. An action had been raised to improve areas raised in this audit and this had been completed.
- Diagnostic images were stored electronically and were available to clinicians through PACS (Picture Archiving and Communications System). We were told there were times that this was not available, however there were only two episodes of this reported via datix in the 12 months between January to December 2015.

Safeguarding

- Safeguarding policies and procedures were accessible to staff online. Staff could explain the process if a concern was identified.
- All staff we spoke to could identify the nurse safeguarding lead.
- Staff completed an on-line electronic learning training module as part of their mandatory training for safeguarding adults and children. At the time of our inspection, 90% of all Parkside Hospital staff (both sites) had completed Safeguarding Adults part A and Safeguarding children 1 and 70% of all Parkside Hospital (both sites) had completed safeguarding of adults part B and safeguarding children 2.
- Two nurses within the outpatients department and three paediatric nurses had completed safeguarding children level three. We were told that most staff in the radiology department had completed safeguarding level two, and two clinical staff level three. Procedures for children were planned so that there was a member of staff who had completed level three training present.
- We were told quarterly supervision regarding safeguarding was carried out and there were good links with the safeguarding lead for Merton local authority.
- We were told of an incident that had happened the day before, where a patient had come in at very short notice with their child. Due to some concerns from the nurse taking their call, an arrangement was made for the safeguarding lead nurse to be present during the consultation in order to assess whether there was an issue that needed to be reported.
- Another member of staff told us of an incident that they had raised recently and was reported to the police as well as social services. Learning from this incident was shared across the department.

Mandatory training

- Mandatory training was completed using an on-line electronic learning package. The training included infection prevention and control, fire safety and information governance.
- Basic life support practical mandatory training was also provided.
- One staff member was allocated responsibility for booking staff onto mandatory training.
- A spreadsheet showing mandatory training completion was kept within the staff room for outpatient staff. An in-house spreadsheet was used to monitor staff compliance for mandatory training in the diagnostic imaging department
- The hospital had a target of 90% compliance for mandatory training. Staff compliance with mandatory training reported for all outpatient staff across Parkside

Hospital (both sites) was above 80% in all areas, except for a new module on informed consent that had only been introduced at the beginning of 2016. The diagnostic imaging department had compliance of over 85% for mandatory training..

- It was part of the contract for the agency providing resident medical officers (RMOs) services that the doctors provided were current in advanced paediatric life support training.
- All of the paediatric nursing staff had completed paediatric life support training within the last 12 months and outpatient nursing staff also reported that they received paediatric resuscitation training.
- Recovery staff in the hospital reported that they received paediatric intermediate life support training in order to care for children after their procedure.
- The radiation protection supervisor was the radiology department lead for paediatrics and had developed a competency booklet for staff to complete to demonstrate their paediatric knowledge and skills.

Assessing and responding to patient risk

- A call bell system was available in all consulting rooms connected to all staff pagers. This had recently been updated so that both floors in the outpatients departments were aware of an issue on the other floor.
- The call bell system in all areas of the Lodge was connected to the front reception desk.
- The hydrotherapy pool always had a minimum of one person on poolside while individual or pair sessions were being run. During group sessions, one person would be on the poolside. For some patients with additional needs, there would also be one to one supervision when in the pool.
- Emergency resuscitation equipment was available and all nursing staff had undertaken intermediate life support training for adults and children.
- In the event of a patient becoming acutely unwell the resuscitation team from the High Dependency Unit would be called, including the Resident Medical Officer (RMO). If the patient was found to be acutely unwell, then a 999 ambulance will be called.
- For children, a 999 ambulance would be called at the same time as the call to the in-hospital team.
- A recent simulated exercise had been undertaken in March 2016, within the outpatient department, where an external company had simulated a child who deteriorated. A report of this had been made available to staff and there was a learning action plan.
- The radiography department undertok stimulation sessions in the MRI each month, to test different emergency scenarios.
- The daily staff meeting held each morning with the nursing team outlined the plan for the day and identify any issues in advance.
- All paediatric pre-assessments were conducted by a paediatric nurse. We were told that this was usually conducted on the telephone. We saw a telephone checklist that was used to assist the nurse who conducted this call.
- The hospital policy stated the recommendation that only children with no pre-existing medical conditions (other than mild dermatological or respiratory conditions, for example eczema or asthma) should be admitted for day case or one night surgical care. We were told by staff that this policy was followed and that they were supported by senior managers when they did not accept a child for a procedure.
- The hospital had a transfer agreement with the local NHS hospital in the event of a child becoming acutely unwell during their time at the hospital. We were told that no children had been transferred during the last two years.

Nursing staffing

- There were 12 full time equivalent (FTE) nursing posts and 8.3 FTE healthcare assistant posts within the outpatient department.
- We were told that staffing was calculated to meet clinic workload and if it increased then staffing levels would be increased accordingly.
- There were currently no nursing vacancies within the outpatients department.
- Nursing staff who were full time, would generally work 12 hour shifts as three long days and part time staff would work from 8am to 6pm or 1pm to 9pm.
- The hospital employed three registered sick children nurses (RSCN). One of these nurses was

employed part time and the other two were bank staff members. We were told that when minor procedures for children were conducted within the outpatient department, these clinics would be arranged at specific times so that an RSCN was always available. This was confirmed by staff within outpatients who told us they would assist the consultant with the procedure and the RSCN would care for the child. The three RSCNs would also provide care for patients in the hospital ward following a surgical procedure.

- Cover for staff leave or sickness was only provided by staff that were part of the existing nursing team or bank staff. No agency staff were used.
- There was a low level of staff sickness with levels across the hospital for October to December 2015 of 3%.

Allied Healthcare Professional staffing

- There were 11 physiotherapists, four physio assistants and one occupational therapist. There were no vacancies within the physiotherapy team.
- Physiotherapists would cover clinics between Monday to Saturdays.
- Cover for staff leave or sickness was only provided by staff that were part of the existing team. There was no agency staff use.
- Within the diagnostic imaging department, there were 20 radiographers and six clinical imaging assistants. There were currently two vacancies due to long-term sickness and maternity leave that were being covered with long term bank staff members.
- There was a low level of staff sickness with levels across the hospital for October to December 2015 being at 3%.

Major incident awareness and training

- Staff we spoke to were aware of the actions required if there was a fire on site.We were shown the evacuation mattress and fire extinguishers that were available in all departments.
- The manger outlined plans for poor weather, including emergency contact numbers if required as the outpatients department was difficult to access in snow. We were told staff sometimes stayed overnight at the hospital in bad weather.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We found:

- Patient care and treatment reflected relevant research and guidance, including the Royal Colleges and National Institute for Health and Care Excellence (NICE) guidance.
- Audits and outcomes of care and treatment were monitored and actions were taken to make improvements.
- There was a good multidisciplinary team approach to care and treatment. This involved a range of staff working together to meet the needs of patients using the service.
- Staff had the right qualifications, skills, knowledge and experience to do their job.
- Staff reported they received regular appraisal and clinical supervision sessions.
- The hospital had started submitting specific data to national audits, although there was not yet sufficient collected to view outcomes.

However we also found:

- There had been a low level of documented consent within the outpatients department for minor procedures. An audit had been introduced to monitor this and actions were being followed up in order to improve compliance.

Evidence-based care and treatment

- The service had local policies and guidelines written in line with national guidance. New or updated policies and standard operating procedures were flagged on an online system and staff were required to submit a password to confirm that they had read them.
- Guidance was provided by the Ionising Radiation (medical exposure) Regulations (IR(ME)R) for the safe use of radiological equipment. This included guidance

for operating procedures, incident reporting, training and equipment maintenance and medical physics' role. These IRMER procedures were accessible to staff on the hospital intranet.

- The physiotherapy procedures were based on the most recent guidance from NICE.

Pain relief

- All clinical staff trained in paediatric phlebotomy were able to administer emla cream, which could be placed on a child's hand to make the skin numb prior to the needle being inserted.
- We saw a pain assessment score being measured for a child after they had received surgery and pain relief being administered to good effect.

Patient outcomes

- The radiology department conducted an internal quality audit four times per year. Results were discussed with the radiologist and fed back to the staff.
- The Radiation Protection Advisor (RPA) (a specialist in radiation safety and compliance matters which relevant organisations must have by law) had conducted an audit in January 2016 and found that the department was nearly fully compliant, with a few minor improvements necessary. The RPA was monitoring an action plan to address these.
- The outpatients department collected numerical data about procedures completed. This included paediatric phlebotomy, 24 hour electrocardiogram recording, and minor procedures, by consultant and by specialty. This allowed them to review what was being undertaken in order to aid future planning.
- The physiotherapy department had been using the framework of the EQ-5D, which is a standardised measure of health status developed in order to provide a simple generic measure of health. It includes assessment of mobility, self-care and daily activities and can be used to assess how a person's abilities change from their initial assessment to their discharge. Outcomes of this were fed back directly to staff and any themes were raised at the staff meetings..

Competent staff

- All new nursing staff to the hospital underwent an induction and completed competency paperwork. Induction periods were tailored to the needs of the individual and area of work.
- We saw a staff log of radiation safety training and all radiology staff had signed to say that they have read the local rules.
- Supervision of nurses within outpatients was undertaken by the senior sister and nursing manager. The supervision of healthcare assistants was carried out by the registered nurses. All staff that we spoke to said that they received regular supervision.
- We saw a competency assessment radiographers joining the department had to complete before they practiced on their own in the department. This included a self-assessment and an intermediate and final assessment. Any additional training requirements would be noted on this.
- Staff directly employed by the hospital all received annual appraisals. All staff we spoke to told us they received an annual appraisal which supported their clinical development.
- We saw a copy of an appraisal that had been completed for a bank member of staff.
- We were told that staff had areas of responsibility rotated at their appraisal in order to increase knowledge and skills.
- Nursing staff told us that they were being supported to prepare for revalidation. Two nursing staff had been through the process and the lead manager held a list of when the rest of the nurses were due. Aspen Healthcare Limited had provided a specific folder for gathering evidence and staff told us this was useful for them.
- Outpatient staff reported additional training that they had completed through the "investing in you" booklet provided by Aspen Healthcare Limited such as a lower limb compression course and said that it was focussed on their needs.
- Healthcare assistants reported they had received extra training in order to learn new skills. This included

assisting with minor procedures, paediatric phlebotomy, dressings and wound care. They felt well supported by nursing staff during training and supervision in these skills.

- The lead radiographers for MRI had recently attended a study day and a mammogapher was undertaking further education in order to undertake biopsies.
- The hospital had a contract with a member of staff at a local NHS hospital to work as the Radiation Protection Advisor (RPA) (a specialist in radiation safety and compliance matters which relevant organisations must have by law) for the radiography department. They provided a yearly update to all staff and also arrange one to one assessments to be signed off.
- We were told about recent local training including a paediatric study day that staff told us was useful.
- All staff undertaking phlebotomy had an annual update and we saw evidence of this.
- We saw evidence of competencies completed for staff who perform blood tests for children and young people. We spoke to two staff trained in this specific skill. They were able to describe the technique they used for this procedure in some detail.
- The hospital had a policy that included a requirement for surgeons and anaesthetists who carried out procedures for children and young people to demonstrate sufficient appropriate activity in order to maintain practising privileges at the hospital. This was reviewed by the paediatric working group.
- We were told the physiotherapy team had received paediatric resuscitation training. Although some physiotherapists had treated children within previous employment, training for paediatric treatment had been identified as being required and two staff were booked on a course.
- We were told recovery staff received lectures on paediatric topics and these were reported as useful by staff. Staff from the hospital theatres also told us that they would attend a local NHS hospital for a day to keep their paediatric knowledge and skills up to date.

Multidisciplinary working (related to this core service)

- We observed good multidisciplinary working with effective verbal and written communication between staff. Staff confirmed that there were good working relationships between physiotherapists, nurses, radiology staff and consultants..
- The nurse manager or lead sister, and physiotherapist would attend the hospital daily huddle which was a cross-organisational group to identify key information that needed to be shared. It included allied health professionals and support staff as well as clinical staff from other departments. The staff who had attended this meeting described the content as useful.
- The imaging department had good links with the local NHS trust to provide staff with additional ongoing training.
- We were told there had been a new liaison link with a consultant paediatric nurse from a local NHS hospital who was delivering training to staff.

Seven-day services

- The outpatients department was open 8am to 8pm Monday to Friday. The department was also open 8.30am to 1.30pm on a Saturday.
- The diagnostic and imaging department provided services 8am to 8pm, Monday to Friday in outpatients. They also operated an on-call rota from home seven days per week for both urgent CT, MRI and X-ray requirements.
- The physiotherapy department provided services 8am to 8pm Monday to Friday. They also opened on Saturday mornings.

Access to information

- The radiology department had a reporting turnaround time of the next day. All reports were done in house and most radiologists used a voice recognition system to assist them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The radiology department used an adapted version of the World Health Organisation (WHO) checklist for injections and fluoroscopy procedures.

Good

Outpatients and diagnostic imaging

- Consent e-learning training had been introduced this year and There was e-learning training on consent was available on via the hospital intranet. So far 75% of outpatients nursing staff, 50% of outpatient healthcare assistants and 44% of hospital allied healthcare professionals had completed this training.
- Consent for minor procedures undertaken in outpatients was completed on the day by the consultant. A checklist was completed for each procedure and handed to the outpatient manager each day.
- The gaining written of consent was recognised as an issue in outpatients and work was being undertaken by the team to improve documentation of consent gained. An audit had been started last year to monitor this. January 2016 results showed that that written consent had been documented 29% of the time, verbal 59% and no consent documented 5% of the time. In April 2016, this had shown improvement with written consent documented 48% of the time, verbal consent documented 40% of the time and no consent documented 1% of the time. Direct feedback of this was given to the consultants who had not documented consent and results were presented at the departmental meeting.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

- Patients received supportive care and treatment.
- The views of children and young people using the service were requested in an appropriate way.
- Interactions between staff and patients were positive.
- The patients we spoke with told us staff were very caring and respectful, and patients felt they were supported emotionally.
- Patients understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.

Compassionate care

- We spoke with fifteen patients within outpatients, diagnostic and imaging and physiotherapy departments.
- All the patients we spoke with were happy with the care they had received and were complimentary about the staff. One patient said, “staff are very friendly,” another said “all staff are kind and caring”.. We observed staff being polite, courteous and friendly with patients, including within consultations where staff spoke to patients in a kind manner, taking time to put them at ease.
- Patients told us they were treated with dignity and respect. We observed that the reception staff maintained patient's privacy at the reception desk.
- Patients were greeted by the reception staff on arrival and informed where they should wait.
- The nursing station was situated within the main waiting are and this meant that staff were seen to be available for patients if they needed any further support or chaperone before, during or after the consultation. We observed that there were chaperone posters displayed in reception..We observed
- We observed a patient being shown to a private room as she wished to breast feed her baby and other staff were informed so she would not be disturbed.
- The outpatients department collected feedback from patients using a feedback form. The results for the latest quarter showed that 95% of patients found the quality of service was very good or excellent and 96% would recommend the hospital to friends and family.
- Feedback was collected from both parents and children and young people about the care that they had received if they had a surgical procedure. The number of responses was low, however in quarter one of 2016, 100% of these said that they were looked after quite well or very well and 92% would recommend the hospital to friends or family. In the six months from May 2015 to December 2015, 87% of the children who responded said that the hospital was friendly and nice, however this dropped between January to March 2016 to 47%. Comments recorded in this feedback included ‘Nurses are nice, comforting and very supportive'.

Good

Outpatients and diagnostic imaging

- The confined space of the treatment area and gym within the physiotherapy department meant that private discussions with patients could be overheard by others leading to a compromise of the patient's privacy and dignity.

Understanding and involvement of patients and those close to them

- Patients told us they were given clear explanations about their care and treatment. They said they did not feel rushed and were given time to ask questions. One patient said, "He (consultant) explains everything to me."
- We observed a consultant explaining medical equipment to a patient and listening and responding to the patient's questions about their treatment.

Emotional support

- Patients told us they felt well cared for and supported and that staff were pleasant and friendly. A patient told us, "They have explained everything to me, which took a lot of stress off me.""
- Clinics were planned so that children undergoing minor procedures within the outpatients department had a paediatric nurse present for the procedure to provide support to the child.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Services were planned and delivered to meet the needs of the local population. New services had been introduced in specific response to local demand.
- Services coordinated appointments to enable patients to see a number of health care professionals in one day.
- Patient's individual needs were taken into consideration when planning care.
- Waiting times for outpatient appointments were within the national referral to treatment time of 18 weeks.

Service planning and delivery to meet the needs of local people

- The environment was appropriate and patient centred. There was sufficient seating available in the waiting areas where free drinks were available.
- Car parking was free and patients told us they did not have problems finding a space.
- Evening clinics in outpatients, imaging and physiotherapy department were provided Monday to Friday and the physiotherapy department ran Saturday morning clinics to enable patient's access to appointments out of normal working hours.
- The physiotherapy team had recently introduced two new assessments in response to local needs. These were a bike fit assessment that assessed adjustment of a bicycle to the correct position and off bike muscle strength assessment and a new mother assessment under a women's health lead that included review of muscle separation.
- The physiotherapy department had also introduced a group hydrotherapy session for patients who had undergone a hip or knee operation. This provided a more cost-effective option for that group of patients.
- The hospital had introduced a regular weekly paediatric phlebotomy clinic in response to requests from parents who wanted their child's blood test conducted at the hospital. Children could also have blood tests taken on days when the trained staff was on duty.

Access and flow

- The national standard for referral to treatment (RTT) time states that 95% of non-admitted patients should start consultant led treatment within 18 weeks of referral. Data provided by the hospital showed that between October 2015 to December 2015, 96% of patients referred to outpatients at Parkside Hospital (Wimbledon and Putney locations) were seen within this 18 week target, and for some specialties many were seen much earlier.
- There were no waiting lists for patients to attend radiology, outpatient or physiotherapy appointments with consultants.

Good

Outpatients and diagnostic imaging

- Patients told us they were mainly seen on time or within 10 to 15 minutes of their appointment. However, complaints to the department included waiting times and one patient told us that they were not happy at the length of time they had been waiting.
- We were told consultants might take more time with a patient which would extend the waiting time. However, patients were always informed of any delays and we observed this during our visit.
- The radiology department and a breast surgeon operated a 'one-stop clinic', three to four times per week, where patients could have a consultation, mammography and ultrasound with options for additional interventional procedures, if required during one appointment..
- The hospital's policy stated that children would not be accepted for surgical procedures if they had pre-existing medical conditions. Staff we spoke to confirmed that this was adhered to and they were supported to refuse admission of patients when appropriate.

Meeting people's individual needs

- Patient Information leaflets were available to patients about their treatment. Staff gave these to patients to take away. Information leaflets were available for a number of procedures including local anaesthetic, 24 hour ECG information and information for teenage girls regarding questions about pregnancy.
- Staff could arrange for face to face interpreting for patients whose first language was not English.
- The hospital could be accessed by patients that had a physical disability. There was disabled parking, a lift and access to disabled toilet facilities. Wheelchairs were available at the entrance to the outpatients department.
- The outpatients department demonstrated good practice by offering patients with back pain the option to lie down to wait for their appointment if they required it.
- The hydrotherapy pool was equipped with a mechanical hoist for patients that might have difficulty entering the water.
- The radiology, physiotherapy and pre-assessment departments told us they would allocate more time for patients with specific needs, such as patients with a learning difficulty, or those who had mobility problems.
- We observed discussion of specific patients due to attend the outpatients department that day during the department daily huddle, so that staff would know people attending that may require more time or support.
- Vulnerable adults, such as patients with a learning difficulty and those living with dementia were identified at the referral stage and steps were taken to ensure they were appropriately cared for. This included a longer appointment time and informing carers or representatives of the plan of care.
- A dementia file was available in the radiology department with up to date guidance from the Society of Radiographers included for staff to view.
- The paediatric phlebotomy trolley contained a selection of books and toys to distract children when they needed a blood test. There were also stickers to give to the child once they had completed the procedure.

Learning from complaints and concerns

- The provider had a policy covering the raising of complaints.
- Patients were asked to comment on their experiences before leaving the department. All the staff we spoke to could explain how they would manage a complaint raised with them locally and how they would escalate it. The outpatient's team aimed to resolved complaints on the same day and ensured that a senior person was able to speak to the patient.
- An annual complaints report including information from all Parkside Hospital locations was collated which reviewed the previous year's complaints, and included key learning and improvements made as a result of learning from complaints.
- Parkside Hospital (Putney and Wimbledon locations) received 113 complaints in the year January 2015 to December 2015. This included complaints for outpatients, surgical and medical services. The main reasons for complaints related to the clarity about aspects of clinical treatment and financial complaints.

Good

Outpatients and diagnostic imaging

We were told that many complaints were around waiting times and a nurse told us of a delay that morning when a patient was booked into the wrong clinic.

- Complaints can arise about the cost of services, so staff tried to manage the patients expectations so that these did not become an issue.
- A board was on view in the outpatients department which included complaints received and actions taken to address them including plans for a new outpatient electronic case notes system, a new patient information leaflet to explain pricing and plans for a new paperless appointment system (in-progress).

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- The leadership, governance and culture promoted the delivery of high quality person centred care.
- Staff were focused on providing the best service they could for all patients regardless of whether the patient funded themselves or was insurance or NHS funded.
- The senior team were knowledgeable about their service issues and continually made plans to improve the service.
- The service proactively engaged staff and the public to comment and be involved with the improvement of the service.
- Staff told us that senior and local managers were visible and approachable.

Vision and strategy for this core service

- The head of radiology was able to describe a clear vision for the service. It included replacement of aging equipment, specifically an MRI machine, and a business case had been written to support this purchase. An additional plan was the redesign of the waiting area to improve privacy and dignity, and increase DEXA service. (DEXA stands for duel energy X-ray absorptiometry and measure bone mineral density). Staff had been involved in this vision by looking at new equipment together, visiting other sites and having a monthly meeting with specialist staff about how to improve the service.
- The hospital had a set of values (beyond compliance, personalised attention, partnership and teamwork, investing in excellence and always with integrity.) We saw that staff demonstrated these values when providing care to patients.
- The physiotherapy team had a plan for refurbishment of the department although space for expansion was limited.

Governance, risk management and quality measurement for this core service

- There was a clear governance and risk management structure and accountabilities for assurance were well defined. The executive team used various methods to gain assurances from the ward to the board. There were various committees in place which communicated into the Quality Governance Meeting and the Medical Advisory Committee (MAC).
- The MAC met quarterly and the minutes for the last three MAC meetings demonstrated that key governance areas were discussed including incidents and practising privileges.
- The hospital held meetings through which governance issues were addressed. The meetings included the MAC meeting, weekly heads of department meeting. Other specialty service meetings took place in their areas and the team leads were responsible for reporting back to staff and escalating concerns to the senior management team.
- A paediatric working group met four times a year and reported to a paediatric operational group. These groups supervised the treatment provided to children and young people and provided assurances to the MAC. Minutes seen for the last three operational groups demonstrated that key governance areas were discussed.
- Daily huddles and regular team meetings provided a way for information to cascade down to team members from managers.
- We saw managers who attended daily huddles also pass on information from other meetings they had attended.

Good

Outpatients and diagnostic imaging

Leadership / culture of service

- Staff we met were all welcoming, helpful and friendly. They were happy and proud to work for the service.
- All staff we spoke with felt valued and said their managers were supportive and approachable. They felt that they were encouraged to be open about concerns.
- Staff reported an open and transparent culture which was apparent during our inspection.
- Quarterly staff forums were held with the hospital director and staff said they were all welcome to attend and participate in these.

Public and staff engagement

- The hospital carried out a patient satisfaction survey that patients were encouraged to complete in order to improve services. Results were compiled into a quarterly report.
- Aspen Healthcare Limited carried out an annual staff survey and a 68% response rate was achieved for Parkside Hospital (both sites). An action plan regarding specific issues raised from that had been collated and was being led by the hospital director.
- Staff within the outpatients department have written patient information leaflets recently which they viewed as positive.We were told of plans to improve the website for the hospital in order to provide more information about care and treatment of children and young people.

Innovation, improvement and sustainability

- The executive team were responsive to requests and suggestions for improvement.
- All staff were focussed on improving the quality of care that they were providing..
- We were told about two new pieces of equipment that had been introduced within the outpatients department. One was a ZIO recorder for a 24 hour electrocardiogram and the other was a vacuum assisted closure (VAC) dressing.

Outstanding practice and areas for improvement

Outstanding practice

- Changing the pre-assessment for patients having breast surgery to involve a breast care nurse to provide additional emotional support and practical information.
- The 'one-stop clinic' operated by the radiology department and breast surgeons operated three to four times per week whereby patients could have a consultation, mammography and ultrasound with options for additional interventional procedures if required during one appointment.
- A feedback questionnaire compiled by the provider on services provided for children and young people asked both parents and children for their opinions with an appropriate language style for children.

Areas for improvement

Action the provider MUST take to improve

- Report all patient deaths, both expected and unexpected, that occur at the hospital to CQC

Action the provider SHOULD take to improve

- Speed up the JAG accreditation process for their endoscopy unit.
- Document and monitor place of death data in order to ascertain how well the service was performing against key benchmarks of the Hospital.
- Implement a written strategy for the oncology and end of life care service to deliver the vision of the hospital.
- Develop a protocol for informing GP's about their patients requiring community end of life care.
- Review how they share incidents where patients have deteriorated and review the policy for pre-assessment to make sure all patients who require a pre-assessment have one carried out to the appropriate level.
- Review the treatment area and gym within the physiotherapy department to improve patient privacy and dignity.
- Ensure all relevant staff are made aware of the learning from never events and incidents.
- Address the nursing staff vacancies, particularly in the recovery suite.
- Improve the anaesthetic cover of the High Dependency Unit.
- Improve staff awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Resolve the ongoing quality issues flagged by the governance system.
- Improve the quality of training and workforce activity data collected by the internal automated systems.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services **The provider did not always notify the Care Quality Commission of both expected and unexpected deaths of patients whilst they were receiving treatment.** Regulation 16 (1) (a)