Nuffield Health Shrewsbury Hospital

Quality Report

Longden Road
Shrewsbury
Shropshire
SY3 9DP
Tel: 01743 282500
Website: www.nuffieldhealth.com/hospitals/shrewsbury

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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?	Good

Overall summary

Nuffield Health Hospital Shrewsbury is operated by Nuffield Health. The hospital has a 30 bedded ward. Facilities include three operating theatres, X-ray and outpatient and diagnostic facilities. The hospital provides surgery, and outpatients and diagnostic imaging.

During our inspection we inspected surgery only. We inspected this service using our focussed inspection methodology. We carried out the unannounced visit to the hospital on 19 July 2018.

Summary of findings

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

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

The main service provided by this hospital was surgery. The hospital provided an outpatient service but we did not inspect it on this occasion.

This was a focussed follow up inspection looking particularly at surgery.

Throughout this inspection, we also followed up on concerns raised at the previous CQC inspection conducted in November 2016. We found:

- On the last inspection we told the hospital they must ensure that the World Health Organisation (WHO) Five Steps to Safer Surgery checklist is consistently completed and adhered to at the hospital.
- During this inspection we saw live examples of the WHO checklist being carried out, however, some of the paperwork in a record we reviewed had incomplete WHO checklist paperwork.
- On the last inspection we told the hospital they must ensure steps are taken to improve the infection rates for surgical procedures.
- During this inspection we saw the hospital had greatly improved the level of audit around infection prevention control and audit results were much better. They had also bought in an infection prevention control lead.
- On the last inspection we told the hospital they must ensure all policies are complied with, specifically the antimicrobial policy, fasting arrangements and ensuring patients had sufficient information and time to provide informed consent about their operation.
- During this inspection found that the hospital complied with the antimicrobial policy, fasting arrangements and ensuring patients had sufficient information and time to provide informed consent about their operation.

We rated this hospital as good overall.

We found good practice in relation to surgery:

- Infection prevention and control was well managed; and was regularly audited to ensure staff compliance. This had been an big improvement from the last inspection.
- We found incidents were managed appropriately. Staff were aware of how to report incidents; and supported to do so. Learning was shared to all staff; including learning from incidents which had occurred within other Nuffield Health locations.
- Staff undertook a range of mandatory training subjects, including appropriate safeguarding training for their grade. We saw that staff training compliance was above target.
- Staff were assessed for their competency to undertake their roles. Staff received yearly appraisals.
- Patient outcomes for certain surgical procedures were measured using the Patient Reported Outcome Measures Tool (PROMs).
- Staff were consistently caring and respectful towards patients. We observed direct patient care whereby staff were compassionate and engaged with patient needs and treated patients with dignity.
- The hospital provides dementia friendly treatment and being a dementia friendly environment. The hospitals dementia toolkit was provided along with a 'This is Me' form, dignity audit and the dementia letter they shared within the hospital. They were also engaging with Dementia Friends and had pledged to train all hospital staff by the end of 2018.
- Staff worked to meet patients' individual needs including dietary requirements; spiritual needs and helped them access support.
- The culture of the service was centred on the needs and experience of their patients which also

Summary of findings

promoted openness and honesty. Leaders encouraged staff to be open and honest with patients when things did go wrong. Staff were proud of the care they provided.

- Senior management had a good understanding of the challenges that the service faced. We found the senior management of the hospital were proactive and sought to rectify concerns quickly.

We found areas of practice that require improvement in surgery:

- WHO checklist paperwork was not always completed in records we reviewed.
- The level of night staffing meant that when one nurse was pulled from the ward then only one staff member would be left to provide patient care on the ward.
- On one occasion we saw the nurse's office door was left unlocked when no nurse's were present and anyone on site could have accessed patient records.
- The latest audit results for records were at 67% for the records on the wards and at 68% for theatres.
- One staff member we spoke to was not aware of the translation service and used a family member to translate.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital. The hospital provided and outpatient service but we did not inspect it on this occasion. The service carried out general surgery and orthopaedics. We rated this service as good because it was safe, effective, caring, responsive and well-led.

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Summary of this inspection

Background to Nuffield Health Shrewsbury Hospital

Nuffield Health Shrewsbury Hospital was opened in 1965 and is situated on the south-west outskirts of Shrewsbury. The Hospital is one of 31 in the Nuffield Health Group. The hospital primarily serves the communities of Shropshire and Mid Wales. It also accepts patient referrals from outside this area. The nearest NHS acute hospital is 1.5 miles away.

There are 30 individual patient bedrooms each with en-suite facilities. The hospital has three theatres with ultra clean air flow, an endoscopy suite and an ambulatory care unit (ACU) adjacent to theatres, which was set up 12 years ago. The outpatient department has ten consulting rooms and two treatment rooms for minor procedures. The diagnostic imaging facilities include digital mammography, ultrasound and x-ray. A mobile Magnetic Resonance Imaging (MRI) scanner was available at the hospital two days per week and a mobile CT scanner one day per week.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, a second CQC inspector, an assistant inspector and a specialist advisor with expertise in theatres.

Information about Nuffield Health Shrewsbury Hospital

The hospital has one ward and three operating theatres and is registered to provide the following regulated activities:

- Treatment of disease, disorder and injury
- Surgical procedures
- Diagnostic and screening procedures

During this inspection, we visited the ward and operating theatres. We spoke with ten staff members including; registered nurses, health care assistants, medical staff, operating department practitioners and members of the senior leadership team. We spoke with five patients and reviewed five sets of patient records.

There were no special reviews or investigations of the hospital on going by the CQC at any time during the 12 months before our inspection. The hospital has been inspected four times, and the most recent inspection took place in September 2016, which found that the hospital good overall.

The registered manager had been in post since December 2010, and is also the Controlled Drugs Accountable Officer.

There were 155 doctors working under practising privileges at the hospital. There were also 116 full time equivalent staff employed, including 41 registered nurses.

Between 1 July 2017 and 30 June 2018, there were 775 inpatient episodes, 3,273 day-cases and 950 surgical out-patients cases. NHS patients made up approximately 40% of the caseload.

Between January and June 2018, 181 incidents were reported, none were considered a serious incident.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The overall average compliance rate for mandatory training is 91% which is above the mandatory training target of 85%.
- Safeguarding policies and procedures were in place at the hospital and staff were able to explain what they would do if they identified safeguarding abuse, safeguarding adults training was at 92%.
- There were systems and processes in place to prevent and protect people from a healthcare-associated infection and staff were compliant with them. Hospital infection prevention audit results were good.
- The design, maintenance and use of facilities and premises kept people safe. Appropriate equipment such as resuscitation equipment was available and well maintained.
- A registered medical officer (RMO) was on site 24 hours a day, seven days a week to provide medical support to the nursing staff.
- Medicines and medicines related stationery were managed safely and securely. Prescription charts were complete, fridge temperatures were measured and controlled drugs were stored securely.
- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses, and to report them internally. Dissemination of learning from incidents took place after incidents.

However;

- World Health Organisation checklist paperwork was not always completed in records we reviewed.
- The level of night staffing meant that if one nurse was pulled from the ward then only one staff member would be left to provide patient care on the ward.
- On one occasion we saw the nurse's office door was left unlocked when no nurse's were present and anyone on site could have accessed patient records.

Are services effective?

Good

We rated effective as good because:

- We saw that the hospital had systems in place to provide care and treatment in line with national guidance and staff were able to give examples of following best practice.

Summary of this inspection

- Patient's nutrition and hydration needs were assessed and met. All patients we spoke with were happy with the quality of food they received.
- Staff managed pain effectively and in a timely manner.
- The hospital recorded Patient Reported Outcome Measures (PROM) and Q-PROM data and audit data then used this information in various governance meetings.
- Staff at the hospital were competent. All consultants were up to date with practising privileges and permanent staffhad regular appraisals. Staff told us learning and development was encouraged by the hospital.
- The staff demonstrated good multidisciplinary working with informative, effective handovers. All staff reported that medical and nursing staff, therapists and pharmacist staff worked in partnership on the ward.
- Staff promoted health and wellbeing to patients. If staff members identified potential health issues with patients they would signpost to appropriate agencies.

However;

- Staff were not always aware of where they could access certain policies.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients compassionately throughout their stay at the hospital. All patients we spoke with reported that staff treated them with kindness, dignity and respect.
- Staff gave patients emotional support throughout their stay at the hospital. Staff could refer patients for psychiatric or psychological support if required.
- Staff provided patients with appropriate information in a way they could understand. All patients had a named nurse.

Are services responsive?

Good

We rated responsive as good because:

- Services were planned and delivered in a way that took people's needs and preferences into account.
- The hospital met the individual needs of its patients. Patients could access information in the format they needed. Staff catered to patients dietary, religious and special needs.
- The hospitals admission process, care pathways and treatment plans were the same for private and NHS patients. Discharge packs which included a letter to the GP were provided to patients.

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- The hospital dealt with and learnt from complaints. They responded to complainants in a timely and compassionate manner and explained any changes that had taken place as a result of the complaint.

However;

- One staff member we spoke to was not aware of the translation service and used a family member to translate. Which is an improvement since the last report, but is not fully embedded.

Are services well-led?

Good

We rated well-led as good because:

- The leadership team had the skills, knowledge and experience to manage the service. Managers demonstrated the ability to understand the challenges and were visible to staff on the wards.
- The hospital had a clear vision and strategy for the hospital.
- The culture of the service was centred on the needs and experience of their patients which also promoted openness and honesty. Staff said the culture of the service was positive and a learning culture was promoted.
- There were robust quality measurement system in place, which were managed by the senior leadership team. The matron captured clinical data and presented this to various governance groups and used it to inform service decisions.
- The hospital engaged with both patients and staff and used the feedback to inform service decisions. They held quarterly patient forum meetings.
- The hospital provided dementia friendly treatment and being a dementia friendly environment.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Good

Our rating of safe improved. We rated it as **good.**

Mandatory training

- We reviewed training records for all staff as of 24 July 2018. The hospital's mandatory training target was set at 85%. The trust met this target in 31 out of 35 areas apart from infection prevention: practical (71%), manual handling (71%), intermediate life support (73%), basic life support (81%). The overall average for mandatory training was 91%. This is the same percentage it was at on the last inspection.
- Sepsis was part of the mandatory training programme. Sepsis was covered in the intermediate life support (ILS) for clinical staff, which is at 73%. All clinical staff were booked on ILS sessions, but unfortunately the trainer could only train six people per session, some staff could not attend in the exact month they were due to re-take the ILS training which created a delay.
- All staff we spoke with told us they felt well supported to complete their training which was either classroom based lectures or e-learning.

Safeguarding

- Safeguarding policies and procedures were in place to ensure that staff understood their responsibilities to protect vulnerable adults and children. Most staff we spoke with were aware of the safeguarding referral process and could describe examples of safeguarding referrals they had been involved in or been told about. They could also describe the type of circumstances when a referral should be made. Safeguarding issues were discussed at ward meetings, if relevant to the service. However, some staff were not able to describe the external processes that should be followed but advised us that there was guidance available which they could refer to.
- Safeguarding adults and safeguarding children and young people level one training was mandatory for all staff. The mandatory training target set by the hospital was 85%. Safeguarding adults training compliance was above target at 92%. Safeguarding children and young people level one was also above target at 91%.
- All staff had undertaken PREVENT training as part of the safeguarding training module. PREVENT training is part of the Government's counter-terrorism strategy and aims to stop people becoming terrorists or supporting terrorism. The mandatory training compliance is at 92%. Monthly mandatory training days that included a further classroom session on safeguarding or PREVENT were undertaken by the Level 3 safeguarding staff.
- The hospital director and matron were required to carry out safeguarding children and young people level three training as safeguarding leads. They were both up to date with this.
- Nursing staff were able to provide examples where they had safeguarded both members of the public and staff at the hospital.

Cleanliness, infection control and hygiene

- All areas of the hospital appeared to be visibly clean. We saw that staff adhered to theatre and ward cleaning schedules. Since the last inspection, the hospital had

removed the carpets from the clinic rooms, as they had previously been highlighted as an infection prevention and control risk. These had been replaced with hard floors which were much easier to clean and were in line with designing health and community buildings (HBN) guidance. The 2018 Patient Led Assessment of the Care Environment (PLACE) score for cleanliness was 99.5% which is above the organisational average of 98.3%.

- There were systems and processes to prevent and protect people from a healthcare-associated infection and staff were compliant with them. These policies and procedures were up to date and available on the intranet. We observed staff complying with these policies whilst on site. Staff were not always aware of where to find policies.
- Adequate hand-washing facilities and hand sanitising gel were available and we observed staff washing their hands and using sanitising gel. The 'bare below the elbows' policy was observed by all staff during clinical interventions and staff were seen to follow the hospital's infection prevention and control policy by washing their hands between patients. The arrangements for the availability of personal protection equipment was effective on the ward. We saw that gloves and aprons were available in each patients room.
- Information provided by the hospital identified that there had been no incidents of Methicillin-resistant Staphylococcus aureus MRSA from June 2017 to June 2018. There had been no incidents of Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile in the same time period.
- According to the hospitals internal infection prevention audit carried out in January 2018 to March 2018 the trust scored 100% on hand hygiene, 100% on cleanliness and 90.5% on decontamination of equipment. We saw action plans in place to address any issue that were raised by the audits. Since the last inspection the hospital had also introduced an infection control prevention co-ordinator who was responsible for carrying out audits and ensuring compliance with infection control policy.
- Between 25 July 2017 and 24 July 2018 there were 18 surgical site infections at the hospital. The main reason for this was post discharge infections of which there were 16. The other two infections were acquired at the hospital. These are not attributed to the hospital. The hospital carried out analysis of this and found no trends.
- The offsite hospital sterile services department ensured that appropriate equipment was available for surgeons. The system promoted the correct flow of dirty to clean equipment, which reduced the risk of contamination.

Environment and equipment

- The design, maintenance and use of facilities and premises kept people safe. All environments we visited, were safe for patients. We saw corridors were uncluttered with equipment and trollies stored safely. The 2018 Patient Led Assessment of the Care Environment (PLACE) score for condition, appearance and maintenance was 85.54%, which was below the organisational average of 94.06%. The hospital identified the main reason for this was the appearance of some areas of the hospital, there was an on going re-decoration plan and all areas would be re-decorated by the end of 2019.
- Resuscitation equipment was available on the ward and in theatre. Records showed that the equipment had been checked daily, with the seal on the trolley being broken and replaced to check the contents. There were no gaps in the equipment checks. This was checked on inspection and also found to be compliant.
- Staff told us suitable and sufficient equipment was available to support the surgical procedures undertaken. All equipment was serviced and maintained appropriately.
- The arrangements for managing waste kept people safe. On the ward waste was segregated appropriately with separate waste bins for both general and clinical waste. We saw sharps bins being used appropriately and none were overfilled.
- Patient moving and handling equipment was available on the ward. This had been maintained and serviced appropriately.
- We saw that the hospital participated in medical device and equipment forums to discuss medical device incidents and concerns. The hospital used a live action plan to manage the replacement and change of equipment.

- The service submitted data to the National Joint Registry database which records implants and protheses used.
- The fire extinguishers on the ward and pre-operative assessment/day surgery department were checked and maintained by an external company. We saw annual checks had recently been carried out on all extinguishers.

Assessing and responding to patient risk

- During pre-admission patients were assessed, considering the planned procedure, for risks to their well-being. High risk patients were treated at the acute NHS provider.
- There were six unplanned transfers out of the hospital from 1 August 2017 to 31 July 2018. Full investigations were undertaken for each one of these events. The various reasons for this were active bleeding of an ulcer, cardiac changes, respiratory issues and issues raised due to an undiagnosed condition. There were no themes and trends identified by the hospital.
- The hospital had a service level agreement with the local acute NHS trust if patients needed to be transferred in an emergency.
- Risk assessments were carried out for people who used services and risk management plans were developed in line with national guidance, however, it was not clear when these assessments were reviewed and we found they did not contain the expected detail. We reviewed five sets of patient records and saw evidence that each patient had been risk assessed for their risks of developing a venous thromboembolism (VTE), suffering a fall or developing a pressure ulcer. On all occasions, these assessments had taken place at pre-assessment appointments, before their admission into the hospital. However, the detail relating to an individual patient's risk was unclear, for example; patient waterlow scores were not recorded. The only details that were recorded were whether they were high, medium or low risk for each assessment. There was some evidence that risk assessments were repeated but the records lacked detail and required staff to tick boxes and not record patient scores. In four out of five records, it was unclear whether a patient's risk for VTE, falls or pressure ulcers had increased or decreased since their admission.
- In all circumstances, where required, risks that were identified were managed appropriately. For example, we saw evidence that when a patient had been identified as being at risk of developing a VTE appropriate measures were implemented, including the administration of anticoagulants and compression stockings.
- The World Health Organisation (WHO) surgical checklist should be undertaken before each surgery. This process, recommended by the National Patient Safety Agency should be used for every patient undergoing a surgical procedure. The process involves specific safety checks before, during and after surgery. The service had made improvements from the last inspection as we observed this process was consistently carried out when we observed. Staff accurately followed the WHO checklist on two occasions and it was completed fully for each patient procedure.
- From the records it was not clear whether the service ensured compliance with the five steps to safer surgery, World Health Organisation (WHO) surgical checklist. We reviewed five patient records and within one we saw that the WHO surgical checklist had not been completed. The patient record contained the checklist but the sign in was the only part of the checklist that had been completed. The time out and sign out sections of the checklist had been left blank.
- Since the last inspection a consistent audit programme of the WHO checklist had been introduced, which included monthly observational audits by senior managers. Staff also received updated training following the previous report. The WHO audit measured staffs practice in each area of the checklist, the categories were green – no risk (90-100% complaint), yellow – low risk (85-89% compliant), amber – medium risk (80-84% compliant) and red – high risk (0-79% compliant). For the ten records audits that had taken place in 2018 the results were 96.85% green and 3.75% yellow. The cause for all the yellow results were consultants rushing due to being behind on a list.
- Whilst in recovery, patients were monitored by the surgeon and anaesthetist. When the patient's condition was stable, the recovery nurses and consultants made the decision that they were safe to return to the ward. The ward nurse then received a handover from the recovery nurse and reassessed the patient.

- On return to the ward, patients observations were monitored at an increased rate until staff were assured that the patient was clinically stable.
- Staff were able to identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing and medical emergencies. On the wards, National Early Warning Score (NEWS) was used to identify any deterioration in patients; this process recorded patient observations enabling early recognition of signs of deterioration which would require escalation to the medical team. The patient's consultant and the hospital matron were also informed when an escalation had occurred.
- Patients were monitored during their recovery from surgery and if they showed any signs of deterioration staff would complete the 'Sepsis Six' assessment. Management of sepsis after admission to hospital usually involves three treatments and three tests, known as the 'sepsis six'. This would be followed by a top to toe assessment.
- Staff were able to seek support from senior staff when patients' conditions deteriorated or required additional input. When a patient was required to return to theatre during working hours this was facilitated by the theatre and bookings team. When required out of hours, the ward nurses would contact the on call theatre team. A member of the senior management team and senior nurse are on call 24 hours day, seven days a week for advice and support. A member of the senior management team was also on call 24-hours a day, seven days a week for advice and support. Patients' resuscitation status was recorded and monitored during consultations.
- The hospital reported one incident of hospital acquired venous thromboembolism (VTE), a blood clot in a vein, from 1 January to 30 June 2018. No specific trends were identified following investigation. We saw that following a change to National Institute of Health and Care Excellence (NICE) clinical guidelines in 2018; the hospital management team, including the medical advisory committee (MAC), had initiated a working group to ensure that assessment of and treatment for VTE was consistent with national standards. This was shared and ratified with the Nuffield Health Group.

Nursing and support staffing

- During our inspection we saw that the staffing levels were sufficient to protect patients from avoidable harm. The hospital used a staffing tool to meet patient acuity or individual dependency needs. Whilst on site we saw hospital rotas and they matched what was needed on the wards and in theatres.
- Staff told us that when working night shifts there were two staff nurses on along with the registered medical officer (RMO). The average amount of people staying overnight fluctuated daily was around 3. This caused problems when a staff member was pulled away from the ward to deal with something not related to patient care. For example, when people came to the hospital front door at night, as the intercom was broken, one of the staff nurses would be pulled off the ward temporarily to deal with this. We saw evidence from the hospital that the intercom would be replaced by August 2018.
- Staff told us that they felt staffing was sufficient and the skill mix was correct on wards but there was room for improvement in theatres. In theatres, if permanent staffing was not sufficient to meet Association of Perioperative Practitioners (AFPP) guidelines the hospital used bank and agency staff to meet the guidelines. In theatres, an audit was carried out by the theatre manager against AFPP guidelines which showed the extra staffing that would be required to meet these guidelines without the use of bank and agency staff. The business case had been put forward by the theatre manager and matron to get two more operating department practitioners in theatres to meet national guidelines. Theatre staff were also attending training courses to get the skills required to help to meet the guidelines.
- When patients became unwell or the wards were busier; bank or agency staff could be requested. Staff rarely had to work over their scheduled hours. Bank and agency use across the hospital was at 9.9%, in wards it was 9.2% and in theatres it was 14.6%. The same bank and agency staff were usually used for consistency.

Medical staffing

- A resident medical officer (RMO) was on the hospital site 24 hours a day, seven days a week. The RMO offered medical support to the nursing staff; although nursing staff told us they had no problems contacting individual

consultants for information or advice. The RMO was informed of all patient theatre lists and we saw that they were included in staff handovers. The RMO's handed over to each other using situation, background, assessment, recommendation (SBAR), this ensued they were aware of the nature and acuity of all patients in the hospital.

- 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, in the event that they were not available.
- Consultants were appraised by their primary NHS employers and this was monitored by Nuffield Shrewsbury.

Records

- Patient's individual care records, including clinical data, were, in most instances, written and managed in a way that kept patients safe.
- We reviewed five patient records, which were accurate, complete and up to date but were not always legible. For example, in two patient records the operation notes were difficult to read. This was an issue as if the patients did experience any complications, and the consultant who operated on them was unavailable, any subsequent healthcare professional reviewing their notes would have difficulty understanding exactly what occurred during surgery. We saw that handwritten notes were signed by the person completing them and patient records contained a list of signatories.
- All the information needed to deliver safe care and treatment was available to relevant staff in a timely and accessible way. The provider used a paper based patient record system which included a care pathway booklet for each patient. The booklet contained the patient's records including observations, nursing/ doctors' notes and risk assessments. Consultants were required to provide a copy of their letters to patient GPs. We did not see copies in patient records as the five records we reviewed belonged to patients who were still admitted. Staff told us copies were provided by consultants and were chased if there were any delays.
- The service ensured that appropriate pre-operative assessments were recorded. Within each of the five records we reviewed, all of them had documentation relating to the patient's pre-operative assessment. All the documentation was complete and included all relevant assessments. However, there was a lack of detail on individual scores relating to risk, for example, pressure ulcers and falls.
- The service ensured that consultants' operating records and the patient clinical record were integrated into the hospital record for the patient. In the records we reviewed, where relevant, we saw that they contained an operation note and a discharge summary. Consultants wrote their operation note and placed either the original or a copy in the hospital's patient record.
- Patient records were stored in the sister's office on the ward which required a code to enter if the door was closed. The sister's office was behind the nurses' station which allowed staff to have clear line of sight. The records were in a lockable cabinet however during our inspection it always remained unlocked. The door to the sister's office was never closed. Staff said there was always someone either at the nurses' station or in the office and so the cabinet was not locked. We did see, on one occasion, the office door open and the cabinet unlocked when there was no one at the nurses' station or in the office.
- The hospital completed quarterly audits of patient records where they audited five sets of patient records. They looked at areas such as risk assessments, consent, infection risk, handover and discharge. The latest audit results for records were at 67% for the records on the wards and at 68% for theatres. There has been increase in some areas including Theatres with regards 'improvement in patients temperatures being recorded in the anaesthetic room' and 'Ward of antibiotic prophylaxis being recorded as given within 60 minutes prior to incision'.

Medicines

- Medicines and medicines related stationery were managed safely and securely. Medicines were stored securely and in line with policy and national guidance. On the ward, medicines were appropriately stored in the clean utility room which could only be accessed using a code. Medicines were stored in a lockable cabinet or a

lockable refrigerator, the keys for which were held by the registered nurse in charge of the ward that day. Storage facilities were clean and tidy, and the temperature of the clean utility room was monitored.

- The ordering, storage, administration and disposal of controlled drugs was safe and in line with national guidance. The trust had an up to date standard operating procedure for controlled drugs which was produced in line with relevant legislation and guidance. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. We saw staff adhering to the policy on the ward. We reviewed the controlled drugs register on the ward and found no discrepancies in stock or administration. However, we did notice that when a small amount of oral morphine solution had been disposed of, the register did not contain a witness signature. We did not observe any patient's being administered controlled drugs.
- Stock takes were completed weekly by ward staff to ensure there was sufficient stock and medicines were in date. The onsite pharmacy also carried out quarterly audits of the medicine on the ward.
- Prescription charts were complete, contained all relevant information and writing was legible. We reviewed five prescription charts and found patient allergies were recorded, all medications omitted had a reason documented and antibiotics were prescribed in line with guidance. If patients required venous thromboembolism prophylaxis, it was prescribed and recorded.
- All medicine fridge checks on both the ward and theatre were completed automatically by sensors. If the fridge temperature dropped outside of acceptable levels, a message was sent to the pharmacist so they could respond whi would come and review the medicines.

Incidents

- There had been no never events or serious incidents reported by the hospital from 1 July 2017 to 30 June 2018. 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.
- There were 181 incidents reported by the hospital from 1 January to 30 June 2018. The most common themes were documentation issues (28), cancelled operations on the day of surgery (19) and equipment or medical device issues (17). The remaining 117 incidents consisted of accidents, information breaches, medication errors, delayed discharges and issues with consent.
- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses, and to report them internally. There was an electronic incident reporting system in use at the hospital, which all staff had access to. When incidents needed to be reported staff were given sufficient time to complete the report on an electronic incident reporting tool, and managers gave them feedback after investigations were completed.
- Staff told us dissemination of learning from incidents took place. Details and action plans were discussed at quality and safety meetings and learning was shared with all staff groups in team meetings.
- There had been no cases of mortality from 1 July 2017 to 30 June 2018. Mortality and morbidity was discussed with the clinical commissioning groups (CCG) on an individual basis when necessary. Any death would be reported nationally and investigated as necessary, including discussions with the local relevant CCG and coroner.
- There was no specific duty of candour training at the hospital but information on duty of candour was available to staff. There had been no incidents that triggered the official regulation but the hospital had a low level that it set itself and were open and honest with patients. We saw patients had been apologised to when operations were cancelled or delayed when we reviewed incident reports.

Safety Thermometer (or equivalent)

- The provider monitored the safety performance of the wards. We saw that information on infection prevalence and performance was displayed on the ward for staff, patients and visitors to see.

Good

Surgery

- Safety thermometer data was recorded electronically. For the six months before the inspection; the hospital was on target for avoiding patient harm such as pressure ulcers or venous thromboembolism (VTE).

Are surgery services effective?

Good

Our rating of effective stayed the same. We rated it as **good.**

Evidence-based care and treatment

- We saw that the hospital had systems in place to provide care and treatment in line with national guidance, such as National Institute for Health and Care Excellence (NICE) guidance, including CG24 blood transfusion and CG28 Diabetes, adult management.
- Hospital staff gave examples of following procedures such as wound care pathways. Although staff were not always aware of where they could find certain policies.
- The hospital had processes to ensure that they did not discriminate on the grounds of protected characteristics. The hospital had an up to date equality and diversity policy. Equality and diversity training was part of the mandatory training programme and had 94% compliance.
- Care pathways based on national guidance supported surgical procedures that were undertaken, for example gynaecology, and hip and knee replacement.
- When reviewing patient records, we saw that cosmetic surgeons followed the Professional Standards for Cosmetic Surgery; for example enabling a 'cooling off' period between the initial consultation and taking consent to undertaking surgical procedures.

Nutrition and hydration

- Patient's nutrition and hydration needs were assessed and met. Following review of patient care records, we saw needs were assessed and management plans were developed. Staff used a nationally recognised tool for assessing and monitoring patients' needs.
- Patients we spoke with told us the quantity and quality of food was exceptional and staff had regularly offered cold and hot drinks throughout the day and night. We saw that patients had access to drinks and snacks at all times.
- 'Nil by mouth' details were discussed with each patient at their pre-admission assessment and confirmed in writing, this was evidenced in the care records. The hospital did not carry out routine nutrition and hydration audits as patients were all short stay, instead they risk assessed on an individual basis.
- The hospitals 2018 Patient Led Assessment of the Care Environment (PLACE) audit identified a score of 93.85% for ward food, which was below the organisational average of 94.17%.

Pain relief

- All patients we spoke with reported that their pain was managed well and they were regularly asked about it. Patient records also indicated that pain management had been discussed with patients and pre and various intra operative options were available.
- We saw that pain relieving medicines were recorded on the patients' administration charts and given when required. We saw that pain scores were recorded to demonstrate the effectiveness of pain relief and patient comfort level.

Patient outcomes

- The hospital recorded Patient Reported Outcome Measures (PROM) and Q-PROM (a requirement from the royal college of surgeons for cosmetic surgery) data. The hospital provided PROM data for: augmentation mammoplasty, carpal tunnel release, cataract surgery, shoulder surgery, rhinoplasty, septoplasty, facelift, blephoplasty, abdominoplasty, hip replacement and knee replacement. The data was shared with the relevant stakeholders, including the medical advisory committee meetings, to ensure that appropriate quality standards are achieved.
- The service also collected data by way of audit on a range of other topics including; cleanliness, pressure ulcers and falls as part of the provider audit programme. This data was used at various governance meetings and actions were taken to improve performance where required.

- All patients returned to theatre at the hospital or to an NHS hospital were recorded electronically. From 1 August 2017 to 31 July 2018, there were three incidents when patients were returned to theatre and six unplanned transfers to another NHS provider. These were investigated and reported. All of these resulted in moderate harm.
- During the same period, there were eight recorded extended lengths of stay. Four of these resulted in no harm and four resulted in low harm.
- From 1 January 2018 to 30 June 2018, there were nine delayed discharges recorded, eight of these resulted in no harm and one resulted in low harm.
- The hospital contributed to the Private Hospital Information Network (PHIN) as of June 2018 they were had an average score of 95.6%, although the response rate was only 23%. The PHIN is the independent, government-mandated source of information about private healthcare, working to empower patients to make better-informed choices of care provider.

Competent staff

- There were 155 doctors working under practising privileges at the hospital. Practising privileges is a well-established process whereby a medical practitioner is granted permission to work in a private hospital. We could not review the personnel files for medical practitioners on site as they were being transferred to an electronic system at the time. We looked at the practising privileges spread sheet carried out by the hospital and saw that everything was in date.
- NHS consultants received individual appraisal summaries and provided evidence of mandatory training from their NHS employer. Consultants who worked solely in the private sector completed the Nuffield Health mandatory training programme which included an annual appraisal. The hospital used an electronic database to monitor compliance, with due dates identified for doctors' appraisals, revalidation, renewal and indemnity, as a part of the practising privileges process.
- Staff told us and we saw that all new staff, including temporary staff, received induction training, providing staff with an overview of all areas of the hospital. New staff were supernumerary to the ward and theatre staffing levels during their planned induction, which was tailored to their previous experience.
- Ward and theatre staff confirmed that appraisals took place regularly and staff told us they had received an annual appraisal. Records showed 96% of staff had had an appraisal in 2017/18, including administrative and clerical staff. The staff who had not were not yet eligible as they were new. Objective setting amongst staff for 2018/19 was under way. All staff we spoke with said the appraisal process was beneficial and positive. Bank staff did not have formal appraisals but had regular 'catch ups' in accordance with the local policy.
- Encouragement and development opportunities were available to staff. Staff told us they had been given the opportunity to develop. An example of where staff had been supported to develop included the opportunity to complete a nursing qualification.

Multidisciplinary working

- The surgical service demonstrated multidisciplinary teamwork with informative handovers and good communication. Patients' individual needs were considered during pre-admission discussions, with treatments and therapies planned. All surgical staff we spoke with told us they found the process positive and effective.
- All staff reported that medical and nursing staff, therapists and pharmacist staff worked in partnership on the ward. Ward rounds took place on a daily basis. There was also a morning meeting between staff representatives from all areas of the service to discuss any patient risks for the day so they could be prepared to respond.
- When patients were discharged, the hospital worked well with external services. A letter was sent to GPs after discharge. The consultants could also refer to a psychiatrist and psychologist if required.

Seven-day services

- Theatres were used flexibly by all consultants within a six-day service. Theatres were open from 8am to 8pm Monday to Friday and from 8am to 4pm on a Saturday.

Good

Surgery

- Theatres were also available for emergency purposes 24-hours a day, seven days a week. To support emergency events, theatre staff were part of an 'on call rota' including a senior manager each night. Out-of-hours pharmacy advice was available.
- There was a registered medical officer (RMO) on site 24 hours a day seven days a week. They were able to access support from consultants who visited their patients daily as part of the pre and post-operative care pathway. The nursing staff told us they had good working relationships with the consultants and had no hesitation in contacting consultants at any time to discuss their patient's condition or care.
- There was always at least one physiotherapist available on the ward seven days a week and on call 24 hours a day. Where required, additional physiotherapy resource could be provided.

Health promotion

- Staff told us if it was identified that a patient had factors which impacted on their recovery including any general health and wellbeing issues they would offer advice, provide written information in the form of leaflets and signpost agencies who could provide long term support.
- The hospital undertook health promotion pre-assessment. It had a variety of leaflets around alcohol consumption, smoking and weight loss.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were provided with relevant information including the benefits and risks of procedures at the initial consultation. Patients re-confirmed their consent to procedures at the pre-admission assessment and on the day of surgery. Patients we spoke with told us the consultant had discussed the procedures during their assessment. We saw evidence of consent being discussed and obtained within patients' records. On the day of surgery, patients were visited by their consultant and asked to sign a consent form, which included previously discussed risks. On the forms we reviewed, all included associated risks but there was some information missing. For example, two forms had been signed by the consultant but their full names were missing.
- We were assured that staff ensured informed consent was given by patients before their surgery. Before surgery, patients attended consultations with the consultant carrying out their prospective procedure. During which patients were advised on the type of surgery they were having, along with any associated risks. In the five records we reviewed, all consent forms had been signed by the patient on the day of their admission after reflecting on the decision.
- It was unclear when a patient's mental capacity to consent to care or treatment was assessed and recorded. For example, we saw consent forms in each of the five records we reviewed but they had all been signed by the consultant and patient on the day of their surgery. There was no reference to any mental capacity assessments being carried out at any time before this.
- Mental Capacity Act (MCA) training was at 97% and Deprivation of Liberty Safeguards (DoLS) training was at 89% which was above the hospitals target of 85%. The hospital referred any mental capacity assessments to the local NHS trust teams.
- Consent to treatment training was at 93% which was above the hospitals target of 85%. Staff understood Nuffield Health's policies for the resuscitation of patients and 'Do Not Attempt cardiopulmonary Resuscitation' (DNACPR) decisions. The policy stated that unless otherwise requested, all patients that had a cardiac arrest were to be resuscitated.

Are surgery services caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

Compassionate care

- All patients we spoke with reported that they had received compassionate care and were treated with kindness, dignity and respect throughout their stay. We saw patients had their preferred names noted on the front of their care records. On each occasion, staff addressed patients by their preferred name and showed interest in what was being discussed. Staff introduced themselves by name and told patients what their role was.

Good

Surgery

- We observed staff interacting with patients in a dignified and respectful way. Staff were seen knocking on closed doors before entering rooms.
- Patients were assisted where necessary, this included repositioning, personal health needs and assistance with eating and drinking.
- The hospital collected monthly patient satisfaction scores. The average score for likelihood to recommend the service to friends or family from March 2018 to June 2018 was 91%. This was above the Nuffield Health target of 90%.
- Staff carried out assessments of patient comfort and the scores were noted in records. This was a standardised way of understanding how the patients were feeling after surgery.

Emotional support

- Patients' needs were always assessed by staff to ensure they were emotionally stable. Patients were given emotional support from staff throughout their stay in the hospital. Staff could refer patients to psychiatrists and psychologists if they deemed it necessary or the patient requested it.

Understanding and involvement of patients and those close to them

- We saw that information was provided in a way patients understood. Patients told us they knew the reason for their admission, including the risks involved, and this was explained to them during their initial consultation and again on admission. They told us the consultant ensured they fully understood the reason for the surgery or procedure. Patients followed the same admission process and received the same information for day care or inpatient care.
- All patients had a named nurse which provided consistency of care.
- All patients we spoke to felt listened to by staff.

Are surgery services responsive?

Good

Our rating of responsive stayed the same. We rated it as **good.**

Service delivery to meet the needs of local people

- Services were planned and delivered in a way that took people's needs and preferences into account. Admission dates for each patient were planned during initial consultations to include patient choice and inpatient or day case bed availability. The booking co-ordinator and theatre manager arranged the operating lists for theatre in collaboration with each consultant surgeon's secretary.
- The physiotherapy team planned individual treatment schedules from admission to discharge. Following discharge the patients could attend the Nuffield Recovery Plus programme. Rehabilitation was based on patients' assessed needs; this included support from physiotherapists, personal trainers and consultants to promote enhanced recovery. This service was not available to NHS patients.
- The hospital did not provide emergency care and all admissions were planned and arranged in advance. The hospital had a service level agreement (SLA) with the local NHS trust with regards to dealing with emergencies that may arise.

Meeting people's individual needs

- Patients received information they required before their procedure or surgery. Patients told us they understood the reason for their admission to hospital and staff explained the risks and benefits to them.
- Consultants could refer patients to a consultant psychiatrist or clinical psychologist if they required it.
- The hospital was fully accessible for disabled people, it had lifts for access and disabled toilets.
- There was a variety of leaflets available for the surgical procedures on offer at the hospital. We saw that nurses and consultants gave information leaflets to patients to ensure they were fully informed about their procedure or the surgery.

Good

Surgery

- Dietary preferences were noted and a choice of meals was offered. The service covered cultural needs and vegetarian/vegan meal options. Hot and cold drinks were offered throughout the day.
- Arrangements were in place to access translation services however, not all staff were aware of the service. Some staff we spoke with told us they knew about the service and used it when patients, whose first language was not English, attended pre-operative assessment and when admitted on to the ward. However, one member of staff told us they had used a family member to interpret for them on occasion.
- There were no set visiting times at the hospital, visitors were asked to contact the hospital first to see if it was appropriate to visit.
- The hospital had access to chaplaincy services that covered many religions if it was requested.
- All patients had individual bedrooms, private en-suite facilities, a television and thermostatic controlled heating.
- The needs of patients living with dementia or those who had a learning disability were identified at pre-assessment. Staff gave us examples of tailoring patients care based on individual need such as; patients with dementia were always in rooms next to the nurse's station. Staff were taking part in specialist training with dementia and there was specialist dementia signs that could be used on the wards.

Access and flow

- The admission process, care pathways and treatment plans were the same for private and NHS patients.
- From 1 July 2017 to 30 June 2018 for NHS e-referral, the hospital did not achieve the target of 90% of admitted patients beginning treatment within 18 weeks of referral or the 95% target of non-admitted patients beginning treatment within 18 weeks of referral. The hospital achieved 84% of admitted patients and 75% of non-admitted patients. Breaches were largely due to late referrals from an external provider. This meant that they were unable to assess and complete the requested treatment within the national target timescale. This information had been shared with the appropriate CCG. They recognised this and have confirmed that the hospital will not be penalised or fined as a result. However, there was no alternative but to report these breaches against the hospital.
- Discharge packs which included post-operative advice and guidance including a GP letter, check-up appointment, medication information and wound care advice were provided to patients.
- From 1 January to 30 June 2018 there were 287 cancelled operations. We saw that all cancelled surgeries were re-scheduled within 28 days and a full apology was given to patients where appropriate. The most common cause of cancellation were patients feeling unwell.

Learning from complaints and concerns

- We saw 'How to make a complaint' booklets around the hospital, which were available for patients to read.
- From 1 August 2017 to 30 June 2018 there were 40 formal complaints made to the hospital. Ten of these complaints were not upheld, 18 were upheld, six were partially upheld, four were withdrawn, one was rejected and one was still open at the time of inspection. 12 of these were related to hospital charges and six were related to both administration and clinical care.
- We reviewed six complaints files whilst we were on site. We saw the hospital responded in a timely manner, responded to patients compassionately and explained any changes that had been made to the service as a result of the complaint. We saw an example of where the hospital had changed a piece of furniture after a complaint from a patient.

Are surgery services well-led?

Good

Our rating of well-led stayed the same. We rated it as **good.**

Leadership

- Managers had the skills, knowledge and experience to manage the service. Managers demonstrated the ability to understand the challenges they faced and developed plans in order to deal with these challenges.

- There was a Nuffield Health senior management team externally who had oversight and made comparisons to all of their services.
- Staff on both the ward and theatre felt well supported, respected and listened to by their managers. Since the last inspection a new theatre manager had been appointed and all staff we spoke with told us they had a positive impact on the service.
- We were told by staff that the senior leadership team were very visible, speaking with the nursing staff and ward managers frequently. We were told by all staff that the senior leadership team were seen around the hospital almost every day.

Vision and strategy

- There was a clear vision and strategy for the hospital. Staff throughout the service were clear on their contribution to the hospital achieving its vision. The hospital had its own vision and strategic goals which matched up with the five CQC domains. They included specific objectives which were achievable and matched up to the Nuffield Health values of ethical, aspirational and responsive.

Culture

- A learning culture was described where staff development was supported and encouraged. Staff had one day a month dedicated to further learning and team meetings. Staff told us that this day was well utilised and was well supported by managers and senior leaders.
- The culture of the service was centred on the needs and experience of their patients which also promoted openness and honesty. Leaders encouraged staff to be open and honest with patients when things went wrong. Staff told us they felt comfortable approaching colleagues, supervisors and managers if something had gone wrong and were supported in dealing with issues. However, some staff did say there could be a blame culture in some areas of the hospital.
- Staff told us they felt proud and positive to work for the organisation. Staff told us the things they were most proud of and for most it was the teamwork and the care they delivered.
- Staff generally found the hospital a good place to work. We saw that 37.7% of staff had worked at the hospital for over 10 years and they were proud to demonstrate their commitment to the management and patients.

Governance

- We saw a robust quality measurement system in place, which was managed by the senior leadership team. The matron for the hospital took the lead and captured clinical data from the central database to present the clinical governance quarterly and annual reports to the senior management team. These reports identified trends and variances of all patients admitted to the hospital generating an incident report when a variance was noted. The report included complaints, incidents and patient satisfaction survey results. A comparison was made with previous reports and other hospitals in the group including readmission rates and extended lengths of stay. The clinical governance report was also shared at the Medical Advisory Committee and Quality & Safety Committee.
- Monthly business reviews are undertaken where each head of department is invited. They discussed workload, staffing, risk and action plans along with use of agency staff and recruitment.
- Audits were required as part of the Nuffield group and data analysed centrally by the provider to provide national comparisons.
- There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. For example, there were thorough processes for the granting of practicing privileges. At the time of our inspection, the provider had 155 consultants working under practicing privileges. The provider had an up to date practicing privilege policy, dated May 2018, which was being adhered to. As part of the policy, consultants were required to provide evidence of:
  - General Medical Council registration and licence to practice;
  - Infectious disease immunisation status;
  - References from colleagues;
  - Adequate insurance or indemnity;
  - Appraisal and revalidation;

  - Compliance with data protection legislation;
- All consultants were also required to apply for a disclosure and barring service (DBS) check. DBS teams carried out criminal record checks that result in DBS certificates being issued to an individual. Employers asked to see this certificate to ensure that they are recruiting suitable people into their organisation. We saw the provider's records in relation to the consultants operating under practicing privileges and saw that all of them had provided the required evidence. The provider had an effective electronic system for monitoring this and we saw evidence that the provider had achieved 100% compliance in May 2018. The doctors files were not on site at the time so we could not see them. However, if a consultant failed to comply with the policy in terms of documentation, their privileges would be suspended until it was provided or permanently removed if they failed to provide it before the expiry of an imposed deadline. If this happened the consultant would have to complete the application process from the beginning.
- All staff we spoke with understood the management structure at the hospital and knew who they were accountable to.

Managing risks, issues and performance

- The Medical Advisory Committee (MAC) held meetings every three months. We saw that agenda items discussed included the hospital risk register, updated to National Institute of Health and Care Excellence (NICE) guidelines, and shared learning across the Nuffield Group. Practicing privileges were discussed; with a robust framework in place to manage consultants who were not practising regularly at the hospital. The senior management team reported they felt supported by the MAC to address any concerns regarding consultant practice.
- There was one risk register for the whole hospital which logged all the issues identified on site. It categorised any issues and had a clear risk rating system of mild, moderate or severe with a green, amber and red colour rating. The hospital identified dates to review the issues before they were closed and any mitigation that needed to implemented to reduce risk. The matron had oversight of the risk register and updated this regularly, reporting on changes during MAC meetings.
- The hospital had a regular audit programme which involved a peer review programme, using staff from other Nuffield Hospitals. Action plans were developed for any learning points identified from these audits.

Managing information

- We saw that patient records were mostly stored securely; although at times whilst we were on site the door to the Nurse's office was left unlocked along with the cabinet when no one was in or near the Nurse's office.
- Staff records were in the process of being transferred to electronic records so were off site at the time of our inspection.
- There were effective arrangements in place to ensure that data and notifications were submitted to external bodies when required.

Engagement

- The service provided a patient forum group which held quarterly at the hospital and chaired by the hospital director. We saw minutes from the patient forum group which identified that the hospital took patients thoughts into account, for example they had a privacy, dignity and dementia committee. This group included high levels of constructive engagement with staff and people who use the services, including all equality groups and the senior management team. Members of the patient forum group also participated in audits at the hospital. The hospital also reported on patient satisfaction scores to the patient group. The chair of this group also attend MAC meetings to ensure that information was shared at all levels.
- 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 planned and held on the same day as the learning days. Attendance was high and staff were able to discuss any issues and changes in policy and guidance. Meeting minutes were stored on the hospital intranet and paper copies were placed on the notice board.

Learning, continuous improvement and innovation

Good

Surgery

- The hospital put in lots of work around dementia friendly treatment and being a dementia friendly environment. The hospitals dementia toolkit was provided along with a 'This is Me' form, dignity audit and the dementia letter they shared within the hospital. They were also engaging with Dementia Friends and had pledged to train all hospital staff by the end of 2018.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital provided dementia friendly treatment and being a dementia friendly environment. The hospitals dementia toolkit was provided along with a 'This is Me' form, dignity audit and the dementia letter they shared within the hospital. They were also engaging with Dementia Friends and had pledged to train all hospital staff by the end of 2018.
- The hospitals patient forum provided high levels of constructive engagement with staff and people who use the services. They participate in audits across hospital and the chair also sits on the MAC to provide all relevant information back to the forum.

Areas for improvement

Action the provider SHOULD take to improve

- The registered manager should ensure that patient's risk for VTE, falls or pressure ulcers are monitored throughout a patients stay at the hospital.
- The hospital should ensure that its World Health Organisation checklist paperwork is fully completed at all times.
- The registered manager should consider that the night staff levels are adequate enough to ensure that patient care is not compromised.
- The registered manager should ensure patient record audits are continued to evidence improvement.
- The registered manager should ensure that patient files and personal identifiable information are stored securely at all times.
- The registered manager should ensure that all staff are aware of where they can access policies and guidance if needed.
- The registered manager should ensure that all staff are aware of the translation service and use it instead of using family members.