The Hospital Medical Group Holdings Limited

Hospital Medical Group - Dolan Park Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Surgery	
Outpatients and diagnostic imaging	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Hospital Medical Group Holdings Limited, also known as The Hospital Group, has been established for over 20 years. Dolan Park Hospital commenced operating in 2006 and provides specialist private hospital care to patients from all over the UK. It is a purpose built hospital that offers a comprehensive range of cosmetic surgery and weight loss surgery options, including breast enlargement, liposuction and gastric band.

The hospital has 30 private rooms, five consulting rooms and four operating theatres. The hospital also has private twin room facilities for friends or relations who are having procedures together. In total the hospital had 31 beds.

We carried out a comprehensive announced inspection of Dolan Park Hospital on 19 and 20 May 2015 and an unannounced inspection on 28 May 2015, as part of our second wave of independent healthcare inspections. This was a pilot inspection and was undertaken to further develop the methodology we will use to inspect all independent healthcare providers.

We have not published a rating for this service. CQC does not currently have a legal duty to award ratings for those hospitals that provide solely or mainly cosmetic surgery services.

We inspected the following two core services:

- Surgery
- Outpatients department.

The hospital also hosts the head office functions of The Hospital Group which were not directly inspected.

Our key findings were as follows:

Are services safe?

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

- Staff were encouraged to report incidents and there was an incident reporting system in place that staff were aware of. However, we found examples of incidents that had not been reported.
- Feedback from incidents was varied and we were not reassured that staff learnt from all reported incidents.
- There were clear strategies for minimising the risk to patients. Staff demonstrated a good understanding of the assessed risks and how to avoid these. The hospital did not have the facilities to manage patients who required critical care support. A transfer policy was in place in the event a critically ill patients needing to be transferred to a NHS hospital via an emergency ambulance for higher level care. The hospital had a screening system in place to ensure that patients were assessed pre-operatively to ensure their suitability for surgery and used an early warning system to alert them should a patient's condition deteriorate in the post-operative phase. We noted that there had been five cases of unplanned transfers to an NHS hospital in the past twelve month reporting period.
- Dolan Park Hospital did not have a formal service level agreement with an ambulance company or NHS hospital for transfer of patients. Staff told us that if there was a requirement to transfer a patient West Midlands Ambulance Service provided support and the patient was accepted into The Alexandra Hospital in Redditch. This meant that there was a risk patient treatment and care planning could be delayed because patients would need to go via an emergency department.
- As part of planned urgent contingency care, senior staff told us that they had an informal agreement in for the transfer of bariatric patients to a local NHS hospital which provided bariatric surgery.
- Staff did not know when this agreement would be formalised.
- Most staff were not aware of the new duty of candour regulations (where people who use services are told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result).

Summary of findings

- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists registered with the General Medical Council (GMC) who were mainly employed by other organisations (usually in the NHS) in substantive posts and had practising privileges (the right to practice in a hospital) with Dolan Park Hospital.
- The three dentists worked with practising privileges. Their General Dental Council registration, Disclosure and Barring Services (DBS) check, hepatitis B status and professional indemnity cover were checked prior to them being able to work at Dolan Park Hospital.
- The RMO provided out-of-hours medical cover 24 hours a day and staff said that consultants could be contacted out of hours.
- No system was in place to analyse arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs in theatre. There was general agreement that recruitment and retention of nursing staff was seen as a priority by the provider.
- Between June and December 2014, there was between 23 to 63% nursing agency usage across the hospital, with the highest user being theatres using up to 40%.
- The records showed that there were no vacancies within the outpatient department or in patient wards.
- Staff were aware of their role and responsibilities with regards to safeguarding and the majority of staff were up to date with adult's safeguarding training. However, staff including the hospital leads for safeguarding were unsure what level training had been provided.
- Staff and managers told us they were up to date with their mandatory training. However, training records examined did not always support this.
- Despite procedures being in place to check equipment we found equipment in surgery that had passed service dates, including all three ward defibrillators. This put patient safety at risk. There were no up to date records to demonstrate that a robust system was in place to maintain equipment on the wards.
- Medications in the outpatients and dental department were stored inside a locked cupboard and/or fridge as required. However, medicines in surgery were not stored safely and securely to prevent theft, damage or misuse, including Controlled Drugs.
- Services were generally clean and equipment was cleaned between patients; however we noted that some areas in patient rooms and the reception area that did not appear to have been cleaned.
- There were adequate hand-washing facilities and soap dispensers, hand hygiene foam and paper towels for staff and patients to use. However, staff did not always use hand sanitiser gel before entering the theatre area and we found clinical waste guidance was not always adhered to in dental services.
- Patient records were up to date, risk assessments had been completed and documented for patients undergoing surgery, including the World Health Organisation (WHO) surgical safety checklists.

Are services effective?

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.

- Surgical and outpatient care delivered was evidence based and in line with nationally agreed policies and practice.
- We saw assessments of people's needs were comprehensive and included the assessment of pain.
- There was limited evidence that audits were being undertaken in all services. There was limited recording of patient reported outcomes.
- There was evidence of good multidisciplinary working across the hospital.
- Services could be provided over seven days to reflect demand.
- The role of the Medical Advisor Committee (MAC) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken.
- There was a process in place for checking General Medical Council and Nursing and Midwifery Council registration, as well as other professional registrations.

Summary of findings

- There was a lack of formal supervision and competency arrangements for nursing staff. Staff had yearly appraisals. However, none of the dental nursing staff had received an appraisal in the last 12 months.
- Staff were confident about seeking consent from patients. However, staff had a varied understanding of the mental capacity assessment process and not all staff reported receiving training on the Mental Capacity Act 2005.
- We found that consent forms in dental services were not always completed. Staff told us that patients were given a copy of their consent form on receiving their care and treatment. However, we observed that outpatients were not always given a copy of their new consent form regarding additional treatment received. This meant that patients could not confirm accurately what further treatment they had received to support any queries they may have.
- Unplanned re-admissions between January and December 2014 was 1%, which was 'tending towards worse than expected' compared to the other independent acute hospitals we hold this type of data for. An audit of the re-admissions had been undertaken but the analysis of the audit would not be available until the end of June 2015.

Are services caring at this hospital/service

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

- Patients were treated with dignity and respect.
- We observed good interaction between patients and staff. Staff explained procedures and gave appropriate information to patients to help them to understand and be involved in decisions concerning their treatment. Initial consultations and pre-admissions assessments were thorough and included consideration of patients' emotional well-being.
- Most patients spoke positively about the care provided by staff. Patients we spoke with commended staff saying they were friendly and very attentive.
- The outpatients department had a patient questionnaire to gain feedback about the service but the response rate was less than 1% of all 6905 outpatients discharged from Dolan Park Hospital during 2013/14. Those that had replied commented that staff were "lovely" and "very attentive."
- In most cases patients privacy was protected, however we found that in some clinic rooms were not soundproofed and conversations could be overheard and the patient comment book held personal details, which could affect the privacy of patients.

Are services responsive at this hospital/service

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

- The patient care coordinators supported patients throughout their time with Dolan Park Hospital and care was flexed to meet the needs of patients. The patients we spoke told us that access to the hospital was good and did not have any concerns in relation to their admission, waiting times or discharge arrangements**.**
- Patients had an initial consultation at various clinics throughout the country to determine whether they were suitable for surgery, followed by a pre-operative assessment. When a patient agreed to go ahead with surgery, staff were able to plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital.
- Information about services provided at the hospital was provided in a way patients understood and appreciated. Staff told us that should a patient have communication problems they were able to address their individual needs. However, not all staff were aware that the hospital had access to an interpreting service.
- Staff said they were able to accommodate people's religious needs both pre and post operatively. They said they could contact the local community that offered support for example, church, mosque, temple or synagogue.
- There was information on the process for making complaints for patients. The hospital had received between 35 complaints between January and May 2015, with 21 related to inpatient care (51%). Seven complaints had got to the appeal stage. Ninety-eight percent of complaints met the 2 working day target for acknowledgement; and 37% met the 20 working day target for an initial response. Average open to close time for complaints and appeals in 2015 was 32 working days. This had improved form 72 working days in 2014 but the complaints lead acknowledge that further work was to be done to improve the process.

Summary of findings

- Staff received feedback about complaints and we saw some learning from complaints across the hospital.

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.

- Staff said that the hospital's values were discussed during their appraisals. However, staff were not familiar with the vision for services.
- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the hospital. Staff reported that all their managers, including the registered manager were visible. Staff told us that senior management were supportive and front line staff felt able to raise concerns.
- There was a clear governance structure in place, with committees such as the governance and risk team feeding into the medical advisory committee (MAC) and hospital management team. The governance and risk committee was also responsible for clinical governance in the hospital. There was no dental representative at governance and risk meetings or on the Medical Advisory Committee, this had not been identified by the groups as a risk.
- The governance and risk committee met quarterly, however one of the clinicians had been on sick leave and the meetings had been deferred until June 2015.
- We were not assured that the senior management team had sufficient control of or oversight of risk within the hospital. The hospital had a risk register in place, however it only had two risks identified. We identified risks that should have been on the register, the senior management team also identified risks that should have been on the risk register during our inspection. The senior management team told us that they would be reviewing the risk register to ensure it reflected the service.
- The senior management team told us that the CQC inspection process had already made a positive impact for staff. For example, the appraisal rates had increased across the hospital and were at 76% in May 2015, compared to 39% at the end of 2014. We were told this was because the team had 'nagged managers' to complete appraisals for our visit. However, we could not be reassured the sustainability of staff receiving annual appraisals.
- The senior management team recognised that the recording of mandatory training within the hospital was an issue and that the data did not always correlate with the training delivered and received by staff. They also acknowledged that there was no escalation to the governance and risk committee regarding poor mandatory training data. This meant that staff were at risk of not receiving appropriate training because the provider did not have accurate records. They assured us that a plan was in place to improve the recording of staff training.
- There was limited evidence that audits were being undertaken in all services to measure the quality of the service. Of the audits that were carried out, we noted that these did not always adequately identify potential risks to patients. For example resuscitation equipment not being serviced. This meant that we could not be assured that risks could be adequately assessed, monitored and mitigated against.
- We saw evidence of practising privileges of anaesthetists and consultant surgeons being reviewed. We saw practising privileges were discussed at the MAC.
- Senior managers attended a weekly meeting, however, there were no formal minutes taken. This meant that establishing a clear audit trial to ensure all actions had been completed was difficult.
- Obtaining feedback from patients was not consistent across the service. Staff told us they were aware of the lack of feedback and were looking at ways of increasing patient involvement.
- The remit of managerial responsibilities for dental services were unclear.
- The hospital became subject to a new regulation (Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) on 27 November 2014. This regulation says that individuals in authority (board members) in organisations that deliver care are responsible for the overall quality and safety of that care. The regulation is about ensuring that board members are fit and proper to carry out that role.

Summary of findings

- The hospital was preparing to meet the requirements related to fit and proper persons. A policy was in draft form and we found evidence that a new senior management member had been subject to the fit and proper persons test before their recruitment had been completed.

We saw several areas of outstanding practice including:

- Excellent multidisciplinary working across the hospital, to ensure that patients received appropriate and timely care.
- A caring and responsive approach to patients after their surgery.

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

Importantly, the provider must:

- Ensure that all equipment used by the service is clean and properly maintained.
- Ensure there are up to date records to demonstrate that a robust system is in place to maintain equipment.
- Ensure the disposal of teeth (including those containing amalgam fillings) follows the waste segregation regulation Health Technical Memorandum 01-07.
- Ensure staff understand the principles and codes of conduct associated with the Mental Capacity Act 2005.
- Ensure consent forms are accurately completed.
- Ensure effective systems are in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users, including ensuring that the risk register is reflective of service risks.
- Ensure that staff mandatory training records are accurate.
- Ensure that dental services have a clear leadership structure and has representation at governance and risk meetings and/or on the Medical Advisory Committee.
- Ensure all medicines are managed and stored safely and securely to prevent theft, damage or misuse, including Controlled Drugs.
- Ensure the provider has a service level agreement in place to ensure timely care planning can take place to ensure the health, safety and welfare of the service users that require transfer to a NHS hospital.

In addition the provider should:

- Ensure all incidents are recorded and staff receive feedback and learn from incidents.
- Ensure staff are aware of the new duty of candour regulations (where people who use services are told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result).
- Ensure a system is in place to analyse arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs.
- Ensure all staff use hand sanitiser gel before entering the theatre area.
- Ensure that staff receive formal supervision, appraisals and appropriate competencies.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery		Potential risks to patients due to the resuscitation trolleys and hoist not being serviced in accordance with the manufacturers guidelines. Systems, processes and standard operating procedures were not always reliable or appropriate to keep patients safe. Monitoring whether safety systems were implemented was not robust. Incidents were investigated to assist learning and improve care. Patient areas were clean, apart from a small number of dusty areas and infection prevention and control procedures were adhered to by the majority of staff. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient risks. Patients received care according to national guidelines such as National Institute for Health and Clinical Excellence (NICE) and Royal College of Surgeons guidelines. Patients received pain relief suitable to them in a timely manner. There was evidence of out-of-hours services, when needed. Staff were varied in their insight into the mental capacity assessment process to protect patients' rights under the Mental Capacity Act 2005 (MCA). There was a lack of awareness by nursing staff regarding the MCA and why they would need to know this information. Nursing and medical staff were caring with patients treating them with dignity and respect and patients were positive about their care and experiences. They received information in a way that they could understand, including the risks and benefits of potential surgery. Patients' privacy and confidentiality was respected at all times. Surgery services were responsive to meet the needs of the patients using the service. The admission, treatment and discharge pathways were well organised and functioned in a responsive manner to changes. Staff worked in a flexible manner to meet the theatre schedule. Information about the hospitals complaint procedure was available for patients and their relatives. The service reviewed and acted on information about the quality of care that it received from complaints.

Summary of findings

The arrangements for governance did not always operate effectively. We could not be assured that risks could be adequately assessed, monitored and mitigated against.
The hospital recognised the importance of patient and staff feedback and there were mechanisms to hear and respond to patient views. Staff were encouraged and knew how to identify risks and make suggestions for improvement.

Outpatients and diagnostic imaging

Medical and nursing staffing levels met the needs of patients using the service and there was good emergency cover. There were good procedures and processes for the management of medicines within the service. However, systems were not in place to monitor all medications in dental services.
There was a culture of incident reporting. However, staff said they did not receive feedback from incidents reported. The environment and equipment were visibly clean and staff followed the provider's policy on infection control but did not always follow national clinical waste guidance.
Treatment and care was provided in accordance with evidence-based national guidelines. There was good practice in monitoring and management of aftercare. This included wound management. Multidisciplinary working was evident. We found there were inconsistencies with regard to the training data. Staff reported their training was up to date but this was not supported by human resources records. Consultant-led, seven-day services had been embedded into the service. Staff confirmed they had not received training on the Mental Capacity Act 2005. However, they were confident about seeking consent from patients. Staff were able to explain benefits and risks in a way that patients understood. We found that consent forms in dental services were not always completed and patients were not always given a copy of their new consent form regarding additional treatment received.
Patients told us that staff treated them in a caring way and were kept informed and involved in the treatment received. We saw patients being treated with dignity and respect.
The outpatient services were responsive to people's needs. Most patients were seen on time and patients said the service was quick and efficient. There were information leaflets available in the reception area

Summary of findings

which provided patients with information on the services available. An interpreting service was available when required. There was no clear system in the outpatients department for staff to learn effectively from complaints received by the provider.
Although staff were aware of the hospital's mission and values they were unable to identify any actions/ developments to improve the service. However staff said they could openly discuss any issues with their colleagues and felt this was positive in making improvements to the service.
Not all risks within outpatient and dental services had been identified and highlighted on the risk register with action taken to mitigate the risk. There was no dental representative at governance and risk meetings or on the Medical Advisory Committee.
There was a lack of audits to measure performance in the outpatient department. Obtaining patient feedback was variable across the service.

Hospital Medical Group - Dolan Park Hospital

Detailed findings

Services we looked at
Surgery; Outpatients and diagnostic imaging.

Detailed findings

Contents

Background to Hospital Medical Group - Dolan Park Hospital

The Hospital Medical Group Holdings Limited, also known as The Hospital Group, has been established for over 20 years. Dolan Park Hospital commenced operating in 2006 and provides specialist private hospital care to patients from all over the UK. It is a purpose built hospital that offers a comprehensive range of cosmetic surgery and weight loss surgery options, including breast enlargement, liposuction and gastric band.

The hospital has specialist General Medical Council registered cosmetic surgeons. They are able to offer operations seven days a week, 52 weeks of the year at a time that suits the patient.

The Registered Manager has been registered for the hospital since 1 October 2010.

We inspected the surgical and outpatient service provided at Dolan Park Hospital, including dentistry.

The hospital had an onsite inspection in December 2013, where the hospital was compliant with the following standards: Consent to care and treatment; Care and welfare of people who use services; Cleanliness and infection control; Safety, availability and suitability of equipment. However, were non-compliant with the standard: Assessing and monitoring the quality of service provision. We then found the hospital complaint with this standard in September 2014.

Our inspection team

Our inspection team was led by:

Chair: Helen Richardson, Head of Hospital Inspections for the Care Quality Commission

Inspection Lead: Charlotte Rudge, Inspection Manager for the Care Quality Commission

The team included seven CQC inspectors and a variety of specialists including surgical registrar, dentist, theatre nurse, pharmacist and an expert by experience who had experience of using services.

Detailed findings

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 visiting, we reviewed a range of information we held about Dolan Park Hospital and asked other organisations to share what they knew about the hospital. These included the General Medical Council and the Nursing and Midwifery Council.

The announced inspection of Dolan Park Hospital took place on 19 and 20 May 2015. We also undertook an unannounced inspection on 28 May 2015.

We held drop-in sessions for staff in the hospital. We spoke with a range of staff in the hospital, including nurses, consultants, allied health professionals, care coordinators and reception staff.

We talked with patients within the hospital. Some people also shared their experiences by feedback cards, email or telephone. We observed how people were being cared for and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Dolan Park Hospital.

Facts and data about Hospital Medical Group - Dolan Park Hospital

Dolan Park Hospital is set in the Worcestershire countryside in Bromsgrove. The hospital has 30 private rooms, five consulting rooms and four operating theatres. The hospital also has private twin room facilities for friends or relations who are having procedures together. In total the hospital had 31 beds.

Approximately 500 surgical procedures a month are carried out at the hospital with the majority being cosmetic and gastric band surgery. In the 12-month period from January to December 2014, there were 7,059 visits to theatre.

In addition to the main theatres the hospital has a fully equipped dental suite for cosmetic dentistry, two treatment rooms for wound care and gastric band adjustments and outpatient consultation rooms.

The hospital also hosts the head office functions of The Hospital Group.

Dolan Park Hospital does not provide diagnostic imaging services for its outpatient services.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Outpatients and diagnostic imaging	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

We have not published a rating for this service. CQC does not currently have a legal duty to award ratings for those hospitals that provide solely or mainly cosmetic surgery services.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Dolan Park Hospital is a specialist cosmetic and bariatric surgery hospital. The hospital has 30 en-suite rooms with 31 beds.

The hospital has four operating theatres that are in use seven days a week, dependent upon demand, with usual daily allocations of 10 hours for a full day or two six-hour sessions. One theatre is dedicated to bariatric surgery and occasional port replacement procedures and the remainder are utilised for cosmetic procedures.

Approximately 500 surgical procedures a month are carried out at the hospital, including cosmetic and gastric band surgery. In the 12-month period from January to December 2014, there were 7,059 visits to theatre. All operating procedures were planned and no emergency surgery took place, although there were 46 cases of unplanned returns to theatre in that period.

During our inspection we spoke with a range of staff at different grades including nurses, doctors, consultants, the in-patient lead nurse and the theatre manager. We spoke with nine patients, observed care and treatment and looked at eight patient medical records. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the hospital.

Summary of findings

Potential risks to patients due to the resuscitation trolleys and hoist not being serviced in accordance with the manufacturers guidelines. Systems, processes and standard operating procedures were not always reliable or appropriate to keep patients safe. Monitoring whether safety systems were implemented was not robust.

Incidents were investigated to assist learning and improve care. Patient areas were clean, apart from a small number of dusty areas and infection prevention and control procedures were adhered to by the majority of staff. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient risks.

Patients received care according to national guidelines such as National Institute for Health and Clinical Excellence (NICE) and Royal College of Surgeons guidelines. Patients received pain relief suitable to them in a timely manner.

There was evidence of out-of-hours services, when needed. Staff were varied in their insight into the mental capacity assessment process to protect patients' rights under the Mental Capacity Act 2005 (MCA). There was a lack of awareness by nursing staff regarding the MCA and why they would need to know this information.

Nursing and medical staff were caring with patients treating them with dignity and respect and patients were positive about their care and experiences. They

received information in a way that they could understand, including the risks and benefits of potential surgery. Patients' privacy and confidentiality was respected at all times.

Surgery services were responsive to meet the needs of the patients using the service. The admission, treatment and discharge pathways were well organised and functioned in a responsive manner to changes. Staff worked in a flexible manner to meet the theatre schedule. Information about the hospitals complaint procedure was available for patients and their relatives. The service reviewed and acted on information about the quality of care that it received from complaints.

The hospital recognised the importance of patient and staff feedback and there were mechanisms to hear and respond to patient views. Staff were encouraged and knew how to identify risks and make suggestions for improvement.

Are surgery services safe?

Incidents were reported and managed appropriately and themes and outcomes were shared with staff.

Staff were not fully aware of the duty of candour ensuring patients always received a timely apology when something went wrong.

Patient areas were clean, apart from a small number of dusty areas and infection prevention and control procedures were adhered to by the majority of staff.A hand hygiene compliance observation by the infection control lead nurse, over a two day period in May 2015, showed that only 13% of staff were seen to have used hand sanitiser gel before entering the theatre area.

Equipment was checked daily on the wards and in theatres. However, all three ward defibrillators were past their service date. Staff were unclear who was responsible for ensuring that servicing had been carried out.

There was suitable equipment in place for use with bariatric patients in theatre, such as a bariatric operating table. However, staff were currently using basic manual handling techniques when transferring heavier patients in theatre. A risk assessment had been carried out as a need had been identified for the use of an assisted transfer mattress (hover mattress), although this had not yet been approved by the hospital board.

We received conflicting information about staff compliance with mandatory training. Information given to us by the hospital indicated that 24% of inpatient staff and 71% of theatre staff had undertaken basic life support (BLS) training. Ward and theatre staff spoken with told us that they had all attended BLS training apart from one part-time operating department practitioner.

There were sufficient nursing staff on duty to care for patients and appropriate arrangements were in place for the storage of medicines.

Incidents

- Nursing staff were knowledgeable about the reporting process for incidents using a paper based hospital incident reporting system. Staff said they were encouraged to report all incidents.

Surgery

- Staff told us they received feedback directly to aid their learning if they had reported an incident and that they were supported by their managers.
- The hospital had reported three serious untoward incidents relating to surgical services for the period between January 2014 and December 2014. We saw actions had been implemented where possible to prevent similar incidents occurring. For example, after the theft of nitrous oxide from outside the hospital, staff were reminded to be more security aware, night security introduced more patrols and CCTV was installed. The provider reported the theft to the police and the local intelligence network and urgent replacement cylinders were ordered to enable surgery to continue the following day without interruption.
- The inpatient services lead nurse was unable to describe what the new duty of candour regulation was. Nursing staff we spoke with were unaware of what duty of candour meant. This meant we could not be assured that staff were aware of the new regulation regarding being open and honest.

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

- The hospital did not use the NHS safety thermometer which is a process for measuring, monitoring and analysing harm to patients and 'harm free' care.
- Information supplied by the hospital demonstrated that there had been no incidence of a hospital acquired infection in the previous 12 months.
- Venous thromboembolism (VTE) screening was consistently at 100% compliance in the last 12 months.
- Ward and theatre staff spoken with were not aware of any system used by the hospital which collected data on pressure ulcers, falls, urinary tract infections, (for people with catheters), and VTE.

Cleanliness, infection control and hygiene

- During our inspection we noted that public areas of theatres were clean and tidy. For example, there we no boxes or equipment blocking the corridors.
- Areas which were accessed by staff in theatres, such as storage rooms and sluice areas were also clean and tidy. We saw that there was a designated clean room for the storage of breast implants.
- Staff told us that operating surgeons did not bring their own implants into the department. One member of staff was responsible for overseeing the ordering and use of all implants in theatres.
- We observed staff carrying out appropriate hand washing techniques in theatres and using personal protective equipment (PPE) when necessary. We noted that hand sanitiser gel was in place at the entrance of theatres and throughout the wards.
- Hand hygiene compliance was monitored by the infection control nurse lead by measuring the usage of hand gels by staff. During an hour's observation over a two day period in May 2015, only 13% of staff were seen to have used hand sanitiser gel before entering the theatre area. The nurse told us they would carry out additional observational audits if they identified low usage of hand gel by the staff.
- We saw theatre staff undertaking thorough cleaning of theatre equipment such as the operating table in between patients.
- We were told that patients undergoing surgery were not routinely swabbed for Methicillin-Resistant Staphylococcus Aureus (MRSA) at pre-assessment.
- Theatre staff told us that they outsourced sterile services to an external company which collected used equipment and delivered sterile sets back to the department. One member of staff was responsible for ensuring that the correct number of sets were being returned and was effectively managing the overall system of sterile supplies. However, the provider told us that several members of staff were able to undertake this process if necessary.
- We saw an appropriate flow of dirty instruments to the sluice area where the used trays were placed in sealed plastic bags and placed in a dirty trolley for collection. This reduced the risk of cross contamination.
- Daily checks of the temperature of medication fridges were being carried out in theatre. Records showed that fridges were kept at the correct temperatures to store medications.
- The temperature of the blood fridge in theatres was also checked daily. The manager used a data logging system in order to continuously monitor the temperature.
- The surgical wards and theatres were visibly clean. There were cleaning schedules in place for the wards;

however we noted that some areas in patient rooms did not appear to have been cleaned. For example, we found that bags used to store emergency suction and oxygen tubing in patients rooms were dusty.
- In ward areas we observed that mats which were used to evacuate patients on the stairs in an emergency were stored on the floor. We noted that the covers were dusty. The cover of one mat on the ground floor had a broken zip which meant that the mat was not sufficiently contained.

Environment and equipment

- Resuscitation equipment was accessible on the wards and in theatre. Each resuscitation trolley had a defibrillator in place (an electronic device used to defibrillate a heart by applying an electric shock to it). We saw evidence that the equipment was checked daily on the wards and in theatres. However, all three ward defibrillators were past their service date and it was unclear as to which member of staff was responsible for ensuring that servicing had been carried out. This put patient safety at risk.
- We saw that a patient hoist on the lower ground floor ward had also passed the date it was due to be serviced. This should have been serviced in December 2014. We drew this to the attention of the ward manager.
- Each ward had a large oxygen cylinder which was transportable in the case of an emergency. However, we found that the cylinder on the lower ground floor ward was empty.
- We noted that the recovery room did not have a system in place to record that equipment had been cleaned, checked and was functioning properly. This meant that there was no evidence to demonstrate that recovery equipment was safe to use. This included critical equipment such as oxygen, suction and patient monitoring devices.
- We saw that there was an appropriate tracking and traceability system in place for all implants used in theatres. For example, we observed that records of implants used on each patient were kept in implant books and recorded in patient's notes. This ensured that implants could be traced back to a particular patient.
- The integrated surgical care record of each patient included a record of the sterile equipment used in theatre and demonstrated that equipment had been sterilised according to best practice guidelines.
- We noted that the temperature of the fluid warming cabinet in recovery was not routinely checked or recorded.
- The manager told us that servicing and maintenance contracts were in place for specialist equipment, such as anaesthetic machines and patient monitoring systems.
- There was suitable equipment in place for use with bariatric patients in theatre such as a bariatric operating table. However, staff were currently using basic manual handling techniques when transferring heavier patients in theatre. We were told a recent risk assessment had been carried out as a need had been identified for the use of an assisted transfer mattress (hover mattress). The theatre manager had not received feedback as to whether the item was due to be purchased and felt that the current manual handling practice was not ideal.

Medicines

- Fridge temperatures in theatres and recovery were recorded daily with the current temperature and range.
- We observed that medicines were not always stored securely. We noted that the outer medication cupboard in recovery, which also held Controlled Drugs (medicines which are subject to additional controls as they are liable to be misused) behind a second cupboard, had been left open. First line medications were readily accessible via the first open cupboard. We were told that the cupboard was left unlocked at the start of each day so that theatre staff were able to access master keys for each theatre. We also found that a metal lockable cupboard which stored anaesthetic medicines such as Propofol (medication that can be used for the induction and maintenance of general anesthesia and sedation) had been left unlocked in a store room in theatres. This meant that some medication, were not stored safely and securely to prevent theft, damage or misuse.
- We noted that appropriate emergency medicines were accessible on resuscitation trolleys in both theatres and on the wards. An appropriate checking system was in place along with an identification of when medications were due to expire.

Records

Surgery

- The hospital used integrated surgical care pathways which documented the patient's journey from admission through to discharge. We saw that the surgical part of the pathway had been completed appropriately.
- We saw that risk assessments had been completed and documented for patients undergoing surgery, such as manual handling, pressure areas and deep vein thrombosis.
- We noted theatre records were completed accordingly along with World Health Organisation (WHO) surgical safety checklists. We saw that each step of the WHO checklist had been completed and signed by a member of staff in theatre.
- We saw that medications given in theatre were appropriately documented on anaesthetic charts.
- PRN medication had been appropriately prescribed on one patient's medication chart in recovery. This included painkillers and anti-sickness medication. PRN is medication that is given 'as required' by the patient.
- Records demonstrated that up to date records were kept of equipment maintenance and servicing in theatres. This included records of faulty or damaged equipment and actions taken. Although we saw that this was an effective system in theatres, it was unclear as to who was responsible for maintaining the same records for the ward. There were no up to date records to demonstrate that a robust system was in place to maintain equipment on the wards.

Safeguarding

- There had been no reported safeguarding incidents relating to surgery at the hospital during the past 12 months.
- The hospital had safeguarding policies and procedures readily available for staff on the intranet.
- Training records seen showed that 81% of in-patient nurses and 100% of theatre staff were up to date with safeguarding training.

Mandatory training

- All staff spoken with told us that their mandatory training was up to date.
- Information given to us by the hospital indicated that 24% of inpatient staff and 71% of theatre staff had undertaken basic life support training (BLS).
- We spoke with staff in theatre and ward staff who told us that they had all attended BLS training apart from one part-time Operating Department Practitioner.
- Staff also told us they had all recently attended manual handling training, which was supported by records.
- The theatre manager told us that staff were supported in further development. For example, two members of staff had completed a surgical first assistants' course in order for them to assist consultants during surgery.
- The theatre manager had received specific blood transfusion training. They told us that e-learning blood transfusion training was due to be arranged for the rest of the theatre staff.

Assessing and responding to patient risk

- We saw that recovery staff used an early warning system to alert them should a patient's condition deteriorate in the post-operative phase. We saw that for one patient who had undergone surgery, the early warning documentation was used effectively. One member of staff was able to describe the documentation which was used and how the system would highlight a deteriorating patient.
- The hospital did not have the facilities to manage patients who required critical care support. We were told that critically ill patients would be transferred to the nearest NHS hospital via an emergency ambulance. The hospital had a transfer policy in place which gave guidance if patients medical condition deteriorated and did not respond to interventions or required investigation or treatment not available at Dolan Park Hospital, to be transferred to a NHS hospital via emergency services. A transfer form was available for handover the patient.
- The hospital had a screening system in place to ensure that patients were assessed pre-operatively and were not deemed as a surgical risk. This included an anaesthetic review and a pre-assessment consultation. We noted that there had been five cases of unplanned transfers to an NHS hospital in the past twelve month reporting period. The hospital provided us with the investigation of one incident where patient mobilisation was encouraged but not forced post-surgery, which was found to be a contributing factor to the patient deteriorating and requiring transfer to a NHS hospital. As a result staff were informed of the importance of ensuring patients mobilised post-surgery.

Surgery

- Dolan Park Hospital did not have a formal service level agreement with an ambulance company for transfer of patients. Staff told us that if there was a requirement to transfer a patient West Midlands Ambulance Service provided support and the patient was accepted into The Alexandra Hospital in Redditch. There was always a surgeon or anaesthetist available to liaise with the Alexandra Hospital to arrange the transfer of care.
- As part of planned urgent contingency care, senior staff told us that they had an agreement in principle for a formal SLA for the transfer of bariatric patients to a local NHS hospital which provided bariatric surgery. Staff did not know when this agreement would be formalised.
- We spoke with the RMO on duty during our inspection. They told us that they carried a bleep and could be contacted 24 hours a day. When on duty, the RMO remained on-site at all times. The RMO told us they were up to date with advanced life support training.
- We saw that theatres did not have an effective system in place to alert all members of staff when an operating list had been altered. The current system involved writing numbers alongside each patient to identify a change in the order of the list. This method was open to errors when communicating the changes with other staff members. We saw that one operating theatre had added a patient by attaching a patient label to the operating list and had added the operation in hand written format. This was not best practice and was identified as a potential risk.
- There was an emergency blood fridge in theatre which stored two units of blood at all times. The theatre manager told us that the units were changed on a weekly basis and were due to be changed today. The blood fridge was maintained by a transfusion link nurse from a local acute hospital. We saw that daily temperatures were taken and there was a data logging system in place. We noted that there was a blood bank register and appropriate transfer forms. There was a blood transfusion policy in place for the hospital. The theatre manager told us that they were able to receive additional emergency blood within 10 to 15 minutes from the local acute hospital.

Nursing staffing

- The theatre manager told us that there was no specific system in place to analyse arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There were no records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.
- Records of the theatre staff rota showed that there was an appropriate number of theatre staff to needs patient's needs on a daily basis. We noted that there was plenty of staff when we visited one theatre.
- The most recent data the hospital provided us with showed that in December 2014, theatres had a 30% nursing vacancy rate which were covered by agency staff. The theatre manager told us that although this was not ideal, where possible the same agency staff were used.
- There was low (0 to 7% between June and December 2014) usage of agency staff for inpatient ward nurses and we were told there were no nursing vacancies at present.
- We observed a team briefing at the start of an operating list, which followed the World Health Organisation (WHO) surgical safety guidelines. The team briefing was led by the operating surgeon. Members of the team introduced themselves and clarified their roles. Patents on the operating list were discussed and issues highlighted. For example, the anaesthetist discussed a patient with arthritis and the surgeon discussed surgical equipment needed. This reduced the risk of errors during the operating list.
- We noted that there was an on-call rota for theatres which was staffed with an appropriate number of staff.

Surgical staffing

- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (usually in the NHS) in substantive posts and had practising privileges (the right to practice in a hospital) with Dolan Park Hospital.
- Medical cover on the wards was provided by two resident medical officers (RMOs) that worked alternate shifts for one week at a time. During their shift, the RMO was based at the hospital 24 hours per day for that week. The RMO was resident on site and was available on-call during out-of-hours.
- The RMO told us that they felt well supported by their employing agency and could request additional help if needed. The RMO told us they had ample time for rest and was rarely called out during the night.

- During their shift, the RMO was responsible for providing medical cover on the ward. Their duties included the monitoring of patients in the ward areas, prescribing medicines and taking blood samples if needed.
- Ward staff told us that the RMO cover was sufficient to meet patient needs because the majority of patients were deemed low risk, only had an overnight stay and did not have complex medical needs.
- The consultants and anaesthetists were responsible for their individual patients during their hospital stay. The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed.

Major incident awareness and training

- There was a business continuity plan that listed key risks that could affect the provision of care and treatment. Each department had guidance available for staff in the event of a major incident, such as a fire or power failure.

Are surgery services effective?

There was limited evidence of how practice was audited against current evidence-based guidance, standards and best practice. There was no monitoring of patient outcomes of care and treatment and participation in external audits and benchmarking was not available.

Staff awareness and understanding and implementation of the Mental Capacity Act 2005 was variable.

Surgical specialties managed the treatment and care of patients in accordance with a range of guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons professional standards.

Food and drink was provided and monitored to ensure patient's nutritional needs were met. There was appropriate access to services and staff out of hours and patients received effective pain relief. The hospital had a range of seven day services in place and consultants were always available in person or via the phone. There was good multidisciplinary working and arrangements to transfer patients to NHS hospitals should their condition deteriorate.

Evidence-based care and treatment

- Staff told us policies and procedures reflected current guidelines and were easily accessible via the hospital's intranet. The hospital's governance lead was responsible for ensuring policies were kept up to date.
- Policies and procedures we reviewed were up to date and in line with current guidance. They followed the steps to safer surgery including the World Health Organization (WHO) checklist. They conducted early warning scores (EWS) documentation and conducted VTE assessments.
- Surgical specialties managed the treatment and care of patients in accordance with a range of guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons professional standards.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief.
- Staff used a pain assessment score to assess the comfort of patients both as part of their routine observations and at a suitable interval of time after giving pain relief.
- Ward staff told us patients experiencing moderate or severe pain after surgery remained in the theatre recovery area and were not transferred to the wards until the pain symptoms were controlled.
- Patient records showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort. The patients we spoke with told us they received good support from staff and their pain relief medication was given to them as and when needed.
- Patients were given an information leaflet to take home which provided information on how to manage pain symptoms following discharge from the hospital.

Nutrition and hydration

- The management of 'Nil by Mouth' prior to surgery was advised at the patients pre-admission assessment. Protocols were in place to ensure that food and fluids were taken in line with consultant advice to ensure the safety of the patient.
- Staff told us they provided patients with food and drink as soon as practicable following surgery.
- Staff were also able to provide tea and biscuits to patients undergoing minor operations before they went home.

Surgery

Patient outcomes

- We spoke with patients who had procedures undertaken at the hospital before. They told us they were very happy to return having had a positive experience previously.
- Information provided by the hospital reported that there had been 46 cases of unplanned re-admissions between January and December 2014 of a total of 7,059 patients treated (1%). We have assessed the proportion of unplanned returns to be 'tending towards worse than expected' compared to the other independent acute hospitals we hold this type of data for.
- An audit of the re-admissions by the hospital identified that patients returning to theatre appeared to apply to all types of surgery, different surgeons, scrub nurse and at a variety of times. It was also identified that many of the delayed healing, infections and return to theatre are weight loss patients who had a significant amount of tissue removed during surgery.
- MAC agreed that as the current benchmark used to monitor individual surgeons return to theatre percentage rate was that of the overall organisations return to theatre rate, the hospital should investigate whether there was an independent healthcare return to theatre benchmark that could be used instead of the organisation rate.
- We asked what national and local audits were carried out to monitor patient outcomes. Staff were unable to tell us how patient outcomes were monitored and how this information would be used to improve patient services. This meant we were unable to assess how the hospital monitored and compared patients' care and treatment outcomes with other services.

Competent staff

- There was a lack of formal supervision arrangements for both ward based and theatre staff. Staff told us that although they had yearly appraisals, they had not received supervisions in between. The theatre manager was unaware that supervisions should have been taking place.
- The RMO told us that they received an annual appraisal from a senior doctor within the agency they were employed by.
- The hospital used electronic learning to provide much of their mandatory training. This was supplemented with face to face learning especially where practical skills were indicated such as resuscitation training and manual handling.
- There was a process in place for checking General Medical Council and Nursing and Midwifery Council registration, as well as other professional registrations.
- The role of the Medical Advisor Committee (MAC) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the ward and theatres. Staff told us they had a good relationship with consultants and resident medical officers (RMO). The RMO attended daily nursing handover meetings.

Seven-day services

- Surgery was performed in the theatres during weekdays and on Saturdays. Theatre lists also operated on Sundays during busy periods.
- The RMO provided out-of-hours medical cover for the inpatient ward 24 hours a day. The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed.
- The pharmacist was available on-call outside of normal working hours and at weekends.

Access to information

- The hospital used paper patient records. The records we looked at were complete, up to date and easy to follow. They contained detailed patient information and copies of scans/test results from admission and surgery through to discharge. This meant that staff could access all the information needed about the patient at any time.
- Information about care was provided in a way patients understood and appreciated. Five patients told us that they had the planned procedure explained thoroughly to them at pre-assessment and when again admitted to the ward prior to surgery. Patients were clear about the risks included in their procedure.

- Patients receiving day surgery underwent the same process of information and consent. Sufficient information on discharge was provided about what to expect following treatment and what to do if they had any concerns.
- We saw that information such as policies and procedures, audit results, performance information and internal correspondence were available to staff on the hospital's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff we spoke with had the appropriate skills and knowledge to seek consent from patients. The staff we spoke with were clear on how they sought verbal informed consent and written consent before providing care or treatment.
- The consultants sought consent from patients undergoing surgery during the initial consultation and again on the day of surgery.
- We looked at the recording of consent for eight patients undergoing surgery at the time of our inspection and found they were fully completed. Patients spoken with told us they were given a copy of the completed form.
- Staff told us that patients who may lack capacity to make an informed decision about surgery were extremely rare. This would be identified at the pre-admission assessment and if any consideration was needed this would be undertaken at this stage.
- Staff told us that they received training in the requirements of the Mental Capacity Act (2005) (MCA) as part of their safeguarding mandatory training. Staff were varied in their understanding of the mental capacity assessment process. Some staff were clear about the MCA and its impact on consent but some staff were not sure of the process to be followed.

Are surgery services caring?

We spoke with nine patients and they all spoke positively about their care and the way they were treated by staff. Staff treated patients with dignity and respect.

Patients were involved in their care and in making decisions, with any support needed. They were communicated with and received information in a way that they could understand, including the risks and benefits of potential surgery.

Initial consultations and pre-admissions assessments were thorough and included consideration of patients' emotional well-being.

Compassionate care

- We saw that curtains were pulled around patients in recovery when wounds were checked post-operatively.
- Staff were attentive and caring in their attitude towards patients in recovery and provided assurance and support where needed.
- In theatres staff were mindful of patient's privacy and dignity. Staff ensured that patients were covered with a blanket when they were vulnerable and unable to look after themselves.
- Patient feedback during the inspection was very positive. All the patients we spoke with commended staff saying they were friendly and very attentive.
- Care observed on the wards was positive and maintained patient privacy and dignity. Staff were friendly with patients. Patient doors were kept closed during treatment conversations to ensure privacy and dignity.

Understanding and involvement of patients and those close to them

- Information about care was provided in a way patients understood and appreciated. Five patients told us that they had the planned procedure explained thoroughly to them at pre-assessment and when again admitted to the ward prior to surgery. Patients were clear about the risks included in their procedure.
- Patients receiving day surgery underwent the same process of information and consent. Sufficient information on discharge was provided about what to expect following treatment and what to do if they had any concerns.

Emotional support

- Patients told us the staff were calm, reassuring and supportive and this helped them to relax prior to undergoing surgery.
- Initial consultations and pre-admissions assessments were thorough and included consideration of patients' emotional well-being.
- Counselling services were not provided at the hospital.

Surgery

Are surgery services responsive?

Surgery services were responsive to meet the needs of the patients using the service. The admission, treatment and discharge pathways were well organised and functioned in a responsive manner to changes.

There was an effective complaints procedure that staff were aware of and that was made available to patients.

There were various means of monitoring patient experiences and actions implemented to continually improve this.

Service planning and delivery to meet the needs of local people

- Patients had an initial consultation at various clinics throughout the country to determine whether they were suitable for surgery, followed by a pre-operative assessment. When a patient agreed to go ahead with surgery, staff were able to plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital.
- Patient admissions for theatre were staggered throughout the day to ensure patients did not experience extended waiting. The lists for theatre were compiled for each consultant surgeon with sufficient time to enable the theatre to be cleared and prepared for the next patient.

Access and flow

- Patients were admitted through reception to the ward and were admitted by the nurse responsible for their care that day. There were theatre lists taking place each weekday and most weekends.
- The patients were seen prior to surgery by the anaesthetist and surgeon for health checks and consent to be given. When ready the patient was ready they walked to the theatre escorted by staff. Whilst in theatre the patient's bed was brought to theatre for the patient to return via a secondary lift to the ward, away from the general public.
- A theatre recovery area was available with dedicated recovery staff. If needed, additional help was available to recovery staff from the theatre operating department staff.
- The patients were seen by the resident medical officer and consultant before discharge and all treatment communicated to the patients GP.
- Staff reported very few delays in the surgery list with any reasons being communicated to the ward to inform the patient and staff. Staff worked in a flexible manner to meet the theatre schedule, often working later hours to ensure the theatre list was completed.
- The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements**.**
- We observed the theatre lists to be generally running on time and patients did not have to wait long once they had arrived on the ward. One patient, however, told us that they had expected their surgery to be performed early in the morning, but they were told, after admission, that their procedure was not scheduled until the afternoon.

Meeting people's individual needs

- Information booklets about the hospital were available for patients. These included room facilities, meals, care expectations, health and safety, discharge and a patient guide which included information on charges and complaints.
- We asked staff about supporting people with communication needs or those with mental health or learning disabilities. They told us they never admitted any patients with those support needs. We did not see a policy to support this statement.
- Staff told us they rarely used interpreters as family or friends normally attended if a patient did not speak English. Staff were not aware if the hospital had access to an interpreting service.

Learning from complaints and concerns

- The hospital had received between 35 complaints between January and May 2015. With over half related to inpatient care (n21; 51%) and 7 (20%) related to surgery.
- There was a complaints policy in place that detailed the different types of complaints and the process for managing these, including escalation of a complaint and appeals. The staff we spoke with were aware of the complaints policy and their roles in relation to complaints.
- Staff told us that they did their best to deal with issues and complaints at ward level.

- More formal complaints were handled in line with the hospital's policy. This would involve the complaints manager undertaking an investigation and liaising with consultants if necessary.
- The patient guide was in all patient rooms contained information on how to make a complaint. This information was also available on the hospital's website.
- Patients told us they did not have any concerns but would speak with the staff if they wished to raise a complaint. The staff we spoke with understood the process for receiving and handling complaints.

Are surgery services well-led?

The arrangements for governance did not always operate effectively. We could not be assured that risks could be adequately assessed, monitored and mitigated against. We identified risks that should have been on the register but were not.

Staff we spoke with were clear that the hospitals vision was to provide a high quality service to patients.

Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the hospital. They described the hospital as a good place to work and as having an open culture.

Vision, strategy, innovation and sustainability for this core service

- There was a focus on patient satisfaction at the hospital and to increase the customer focus of staff, additional 'customer service' training had been given to all staff.
- Staff we spoke with were clear that the hospital's vision was to provide a high quality service to patients.
- The hospital had provided staff with a quick reference guide of pocket size cards with a series of essential prompts, such as the whistleblowing policy, safeguarding information and early warning scores (EWS). This was an innovative way for staff to access information quickly.

Governance, risk management and quality measurement for this core service

- There was a clear governance structure in place with committees such as the governance and risk team feeding into the medical advisory committee (MAC) and hospital management team. The governance and risk committee was also responsible for clinical governance in the hospital.
- Senior nursing staff were aware of the hospital's governance and risk committee, although they were unsure how various aspects of quality and safety within surgery services were measured and monitored. Committee minutes were available for all staff on the hospital intranet, such as health and safety and infection control, however the information shown to us by a staff member related to 2013.
- Of the audits that were carried out, we noted that these did not always adequately identify potential risks to patients, for example resuscitation equipment not being serviced. This meant that we could not be assured that risks could be adequately assessed, monitored and mitigated against.
- Patient satisfaction scores were reviewed through the governance and risk team meetings. Areas which required improvement were highlighted on a monthly newsletter for staff for further focus. For example, these included identified shortfalls pre-operative communication with patients by patient care co-ordinators and surgeons. All staff we spoke with demonstrated an understanding in making sure all patient needs were met and patients also informed us that they were very happy with the service received.
- The hospital had a risk register in place, however the two risks identified did not relate to surgery services. We identified risks that should have been on the register. For example, after an interview with the governance facilitator it was discussed that the proportion of unplanned returns to be 'tending towards worse than expected' compared to the other independent acute hospitals we hold this type of data for and the lack of staff governance training, should have been highlighted on the risk register with control measures implemented.
- We saw evidence of temporary practising privileges of anaesthetists being reviewed three monthly and permanent consultant surgeons being reviewed annually. Reviews included procedure data including revisions, returns to theatre, infection control issues, incidents, complaints, GMC requests, consent audits and patient satisfaction data. We saw practising privileges were discussed at the MAC.
- The senior management team acknowledged that there was no escalation to the governance or risk committee

regarding poor mandatory training data. Instead human resources reported the data to the registered manager at their weekly meeting but this was not minuted or concerns escalated further.

Leadership/culture of service related to this core service

- We saw that managers were highly visible within their respective departments. For example we saw that the theatre manager was often on the floor and spent time talking to theatre staff.
- Staff reported that all their managers and leads including the registered manager were visible. Everyone we spoke with told us that senior staff were supportive and front line staff felt able to raise concerns.
- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the hospital. They described the hospital as a good place to work and as having an open culture. The most consistent comment we received was that the hospital was a friendly place to work and people enjoyed working there.

Outpatients and diagnostic imaging

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Dolan Park Hospital does not provide diagnostic and imaging services within the outpatient department, however cosmetic dentistry is provided.

The Hospital Group provides outpatient services in Dolan Park Hospital. The outpatient department is open from 8:30am to 5pm, Monday to Friday. Extra clinics are also scheduled for the evenings and at the weekend.

As part of this inspection we visited the outpatient departments on 19 and 20 May 2015. We attended and observed wound care, gastric band management clinics and dental treatments. We spoke with two medical staff, two dentists, the manager for the outpatients department, two registered nurses, two dental nurses, a trainee nurse, a dietician and reception staff.

We spoke with 21 patients and reviewed 14 patient records as part of this inspection.

Summary of findings

Medical and nursing staffing levels met the needs of patients using the service and there was good emergency cover. There were good procedures and processes for the management of medicines within the service. However, systems were not in place to monitor all medications in dental services.

There was a culture of incident reporting. However, staff said they did not receive feedback from incidents reported. The environment and equipment were visibly clean and staff followed the provider's policy on infection control but did not always follow national clinical waste guidance.

Treatment and care was provided in accordance with evidence-based national guidelines. There was good practice in monitoring and management of aftercare. This included wound management. Multidisciplinary working was evident. We found there were inconsistencies with regard to the training data. Staff reported their training was up to date but this was not supported by human resources records. Consultant-led, seven-day services had been embedded into the service.

Staff confirmed they had not received training on the Mental Capacity Act 2005. However, they were confident about seeking consent from patients. Staff were able to explain benefits and risks in a way that patients understood. We found that consent forms in dental services were not always completed and patients were not always given a copy of their new consent form regarding additional treatment received.

Outpatients and diagnostic imaging

Patients told us that staff treated them in a caring way and were kept informed and involved in the treatment received. We saw patients being treated with dignity and respect.

The outpatient services were responsive to people's needs. Most patients were seen on time and patients said the service was quick and efficient. There were information leaflets available in the reception area which provided patients with information on the services available. An interpreting service was available when required. There was no clear system in the outpatients department for staff to learn effectively from complaints received by the provider.

Although staff were aware of the hospital's mission and values they were unable to identify any actions/ developments to improve the service. However staff said they could openly discuss any issues with their colleagues and felt this was positive in making improvements to the service.

Not all risks within outpatient and dental services had been identified and highlighted on the risk register with action taken to mitigate the risk. There was no dental representative at governance and risk meetings or on the Medical Advisory Committee.

There was a lack of audits to measure performance in the outpatient department. Obtaining patient feedback was variable across the service.

Are outpatients and diagnostic imaging services safe?

We found that staff were confident in reporting incidents, but did not always receive feedback about incidents they had reported.

The environment and equipment within the outpatients department was visibly clean with the exception of a wooden table with a broken edge. This meant there was a risk of infection as we could not be assured that the table could not be cleaned properly. We found the tops of radiators in the reception area to be dusty and some of the chairs were stained. There were no dedicated pots available for teeth that had been removed which contravened waste segregation regulation Health Technical Memorandum (HTM) 01-07.

Medicines were appropriately managed in outpatients with staff adhering to the hospital's processes and procedures. However, systems were not in place to monitor all medications in dental services.

There was a good system for the storage and retrieval of records. However, we found inconsistences with the completion of records.

We found there were inconsistencies with regard to the training data. Staff said their training was up to date but this was not supported by those records inspected.

Managers said they were aware of the new duty of candour regulations but staff were unaware.

Incidents

- There have been no "never events" reported in outpatients between January 2014 and December 2014. A Never Event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures are implemented.
- There had been no serious incidents reported in outpatients between January 2014 and December 2014.
- There was a paper based incident reporting system used by the hospital. All staff said they were encouraged to report incidents and were able to describe the types of incidents they would report for example, missing records.

- However, not all incidents were reported. For example, a dental nurse described an occasion when a patients treatment did not go to plan resulting in more invasive procedure being required. They said that the patient was informed about what had happened at the time. However the incident was not reported.
- Staff said they did not always receive feedback on the outcome of incidents they had reported. This meant that the provider could not ensure that staff learnt from the outcomes of incidents reported.
- We saw the hospital produced an annual incident newsletter. We saw the newsletter for April 2015 which provided information on who should report an incident and the recent incidents reported. Examples included the correct usage of sharps bins and staff awareness in keeping themselves secure. Dental staff described a sharps incident from an unused needle which had been reported and the Safe Sharps policy was followed including an occupational health referral. During our visit, we saw staff correctly using the sharp bin.
- Managers said they were aware of the new duty of candour regulations (where people who use services are told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result). However, when asked they were unable to provide examples of the new regulation. Staff said they were unaware of the new regulations.

Cleanliness, infection control and hygiene

- We saw the infection control work programme for 2014/15. It outlined the frequency of observational audits and the areas covered by six monthly audits for example, consultation and nurse treatment rooms. The programme identified that infection control training was required which included hand hygiene and aseptic techniques. We did not see any outcomes of the observational audits.
- The outpatient and dental departments were visibly clean. There were adequate hand-washing facilities and soap dispensers, hand hygiene foam and paper towels for staff and patients to use.
- Staff followed the hospital's infection control policy. We observed staff regularly washing their hands and using personal protective equipment, such as gloves and aprons. Staff adhered to the hospital's "bare below the elbows" policy.
- We saw that where necessary, equipment was cleaned between patients.
- We saw the wooden table in the outpatient waiting area had broken edging. This meant there was a risk of infection control as the table could not be cleaned properly. This was brought to the attention of staff.
- Dentistry had a comprehensive (Control of Substances Hazardous to Health) COSHH file containing risk assessments of substances including blood and saliva.
- The dental department had followed national guidance on the essential requirements for infection control as set out in the Health Technical Memorandum (HTM) 01-05: Decontamination in primary care dental practises and a separate area was available for decontamination of used instruments. Staff showed us the steps they would undertake while cleaning and decontaminating instruments.
- The decontamination room had clearly signed dirty and clean areas with separate sinks and followed recommended guidance of maintaining a clear flow of instruments from dirty to clean area. An illuminated magnifier to check the effectiveness of the cleaning of instruments was available and staff told us they used it to check the cleaning of the instruments. The autoclave cleaning equipment had daily and weekly test logs completed. When instruments had been sterilised they were pouched and stored until required.
- The decontamination schedules for in-between patients and at the end of a clinic session were laminated and on display in the decontamination room. We saw the daily decontamination of the dental treatment room, the decontamination room and ultrasonic equipment bath changing had been consistently signed.
- The dental nurse confirmed that the dental unit water lines were flushed daily and a checklist was signed, this was located in the treatment room. No evidence of Legionella risk assessment and prevention was found in the dental department, however the provider was able to evidence that testing for legionella, pseudomonas and e.coliform in water systems had been carried out. The latest test was in January 2015 and showed that the water did not contain these pathogens. A corporate legionella policy was also provided, along with a comprehensive water hygiene assessment carried out at the premises in 2014 (review due in 2016).
- There were no dedicated pots available for teeth that had been removed. Dental nurses confirmed that it was usual practice to dispose of teeth (including those

containing amalgam fillings) into the waste bags for contaminated clinical waste. This contravened waste segregation regulation Health Technical Memorandum (HTM) 01-07.
- A partially completed infection control audit form dated April 2015 undertaken by the infection control nurse had highlighted items for immediate action in the dental department. This included obtaining a new oxygen mask, wall mounted decontamination checklists and using a smaller sharps bin. These actions were seen to have been completed prior to the inspection.

Environment and equipment

- In the outpatients clinic there was no resuscitation trolley. A trolley was available within the ward located on the same floor. The clinic had a resuscitation button which could be used in an emergency to alert for help, the emergency kit was clearly signposted on the doors throughout the department.
- The reception area at Dolan Park Hospital was very busy during our inspection. We observed that while the receptionist was talking to patients it was possible for other patients and visitors to overhear the conversations. This meant that the privacy of patients was compromised. This had not been identified on the risk register.
- The reception area appeared clean and bright but we found the surfaces to be dusty for example; on the top of the radiator. We saw that some chairs were in need of cleaning due to staining.
- The outpatient waiting room was well equipped with hot drink facilities available. We saw this was regularly filled which ensured that people visiting had appropriate access to hot drinks.
- Staff told us there were occasions when access to the computers was difficult. They said their problems were quickly resolved by the information technology team.
- We were informed The Hospital Group were in the process of ascertaining if the weighing scales in clinical rooms at Dolan Park Hospital could be calibrated. We were informed that once this was completed, the patient weighing scales would either be calibrated or replaced if required. This meant that the provider could not ensure that the weighing scales were accurately recording people's weights for the calculation of their body mass index when attending appointments.
- Staff told us they could access bariatric equipment if required.
- We were told that housekeeping staff locked access to the dental department every night.

Radiography (X-rays)

- There was a Radiation Safety Policy for dental services available on the intranet which stated that there was a named overall Radiation Protection Advisor (RPA) and named Radiation Protection Supervisors (RPS). The RPS were all listed in the treatment room. However, the Radiation Protection File was found not to be up to date. The personnel register listed staff that no longer practised at the hospital and contained none of the current dentists and one of the dental nurses.
- The Radiation Protection File contained an RPA site report which recommended a critical examination of the orthopantomogram (OPG, an x-ray image of the whole mouth), machine. This was carried out in July 2014 and showed that action needed to be taken to reduce the radiation doses given to patients in-line with recommended exposure settings.
- We observed that during a consultation, the dentist reviewed an OPG the patient had at a previous appointment. This x-ray did not show all of the information that the dentist required. Following an examination of the patient's mouth, the dentist decided to retake one extra x-ray. The dentist documented the date, nature of the x-ray deficiency, the known or suspected cause of the deficiency and that a repeat radiograph was taken. This was in line with guidance notes for dental practitioners on the safe use of x-ray equipment (Department of Health 2001).

Medicines

- Medications in the outpatients and dental department were stored inside a locked cupboard and/or fridge as required.
- Records showed fridge temperature checks had been completed daily.
- There were no nurse prescribers within the outpatient department. All prescriptions were provided by the resident doctor. During our inspection we observed staff requesting the presence of a doctor to review an infection which resulted in the course of antibiotics and the request for a swab to be taken. We saw the doctor completing the prescription and updating the patient's records with their findings.

Outpatients and diagnostic imaging

- Staff had processes and procedures in place to manage medicines. There was a monthly audit of stock and we saw these had been completed with no issues or concerns highlighted.
- We observed staff checking the expiry date and content of medicines before it was administered. This showed that the safe handling of medicine procedures were being followed.
- Piped oxygen and working wall mounted suction was in place in the dental treatment room.
- An emergency kit box was located within the dental department containing emergency drugs. A log check was signed daily and all the drugs were in date. A portable oxygen cylinder, first aid kit and emergency eyewash solution was also available for emergency use. The portable suction was stored separately which may cause delays in providing all required equipment in an emergency.
- Antibiotics and analgesia (painkillers) were kept in a locked cupboard away from patient areas. All medications seen were in date. There was evidence of monthly checking of the medicines on a sheet on the front of the cupboard. However there were other medications in the cupboard (co-codamol, hypnoval (trade name) anexate and hydrocortisone) which were not recorded on this list. This meant that systems were not in place to safely store and monitor all medications.

Records

- Daily records required by the outpatient clinics were stored within the locked clinical room. This meant that patient's records were secure and there was no risk of personal details being seen or removed.
- All bariatric records were held by The Hospital Group for two years and cosmetic records for six months before being archived externally.
- The manager told us they could usually receive external records within two hours of request.
- Staff told us a summarised version of all records were contained on the hospital's electronic system. Staff said this data should be sufficient to enable the appointment to continue should the records not be present. Staff said they completed a post-operative review booklet and made up a temporary records prior to the master file being delivered. Staff said if there was insufficient information available the appointment would be re-scheduled.
- We examined seven patients' case records which were colour coded dependant on the package of care provided. The records included gastric band assessments and possible adjustment appointments. Records were accurately completed, personalised to the individual and had appropriate risk assessments.
- The records highlighted the patient's personal information and individual goal.
- Pre-treatment dental records were completed as paper records and included patient health screening and a dental questionnaire, dental consultation and treatment plan and quotation. The majority of this information was captured during the initial consultation with the care co-ordinator. Consent forms were also kept with the paper dental records in a lockable cabinet in a locked room. All six pre-treatment dental records we looked at were incomplete and not signed by staff where prompted.
- Patients that were receiving treatment then had electronic records that were maintained by the dentist and dental nursing staff via dental information technology software. This was secured by password protection.

Safeguarding

- We saw the safeguarding policy which was in a pictorial and easy to read format for all patients to understand.
- Staff were aware of their role and responsibilities and knew how to raise matters of concern appropriately.
- Training records showed that all staff had completed their safeguarding adult's training. However, staff including the senior hospital staff were unsure what level training had been provided. This meant that staff employed to work in the outpatients department had some training and knowledge in the procedures for safeguarding adults from abuse.
- Dentistry staff told us that they could find information regarding safeguarding on the intranet.
- Patients said they felt safe when attending outpatient appointments.
- The receptionists told us that when required the security team were very responsive to any issues within the reception area for example, patients displaying challenging behaviour.

Outpatients and diagnostic imaging

- We asked staff if they felt safe when attending a patient who may portray difficult behaviour. One staff member said they ensured they were visible to the receptionists during consultation to promote safe working within the reception area.
- We observed the outpatient clinical room was located independently a floor below the reception area. We enquired what procedures were in place to safeguard staff who were lone working within the clinical room. Staff told us they were unsure of the measures in place but said they would push the fire alarm button should the need arise.
- Staff said they were not aware of the lone working policy.

Mandatory training

- All new employees received a corporate induction that welcomed them to the hospital and introduced them to their respective departments. All staff received mandatory training as part of their induction programme.
- Staff told us they were up to date with their mandatory training. However, training records examined showed us that attendance for most mandatory training was below the expected level; this included 33% of staff completing governance and risk management and medical devices risk assessment and 67% for infection control, wound management and moving and handling. The training records showed that nursing staff had not completed health and safety and fire training. However, staff were 100% compliant with safeguarding and basic life support training. The manager told us that they managed all the training and staff had completed their mandatory training. However, this was not identified in the records seen. We highlighted this to the senior hospital team who recognised that the recording of mandatory training within the hospital was an issue and that the data did not always correlate with the training delivered and received by staff. They assured us that a plan was in place to improve the recording of staff training.
- Occasionally some patients displayed behaviour which could be regarded as challenging. Staff told us they had undertaken conflict resolution training to support them in their role. However, this was not reflected on the training records.
- There was no evidence that the dental staff had received training regarding infection prevention and control.

Assessing and responding to patient risk

- Hospital doctors used the Hospital Anxiety and Depression Scale (HADS) to determine the level of anxiety and depression that a patient may be experiencing.
- Staff were able to assess and respond to a deteriorating patient in line with policy and guidelines. Staff used the adjustment algorithms found in the management of aftercare procedures to assess and respond to any risk from their gastric bands.
- We observed the management of a patient who needed urgent response to their gastric band insert. We observed good clinical emergency management skills by the senior nurse.
- Risk assessments were undertaken in areas such as moving and handling. These were documented in the patient's records and included actions to mitigate the identified risks.
- There were clear strategies for minimising the risk to patients. Staff demonstrated a good understanding of the assessed risks and how to avoid these. Staff said the management of patient's condition was on-going, with each patient's needs being individually assess and dealt with during their clinic appointment.
- There was an emergency call buzzer in the dental room. Dental staff were able to discuss what actions and responsibilities they had in the event of a medical emergency and reported to have received first aid and cardio-pulmonary resuscitation training; however there was no available evidence of this.

Nursing staffing

- There were no agreed national guidelines as to what constitutes "safe" nursing staffing levels in outpatient departments. Throughout our inspection staff said they felt they were adequately staffed.
- The outpatient department at Dolan Park Hospital had three registered nurses and one health care assistant. Staff felt that the nursing numbers and skill mix met the needs of patients.
- The outpatient manager told us some staff picked up additional shifts to support additional clinics. During October 2014 to December 2014 it was reported that there was no use of agency staff within the service.

- There was general agreement that recruitment and retention of nursing staff was seen as a priority by the provider. The records showed that there were no vacancies within the outpatient department.
- The outpatient services had a 100% validation rate for the registration of nurses working in the department. This meant that patients were protected and were treated by nurses fit to practise. The dental department employed two dental nurses; one fulltime and one who worked one day a week. The part time dental nurse also provided cover for when certain procedures were carried out requiring two dental nurses to be present (dental implants) and also for annual leave. Any short term absence would be covered by agency staff which would be arranged through the care co-ordinator and the lead dental nurse would be informed. Dental nurse agency use was minimal, with 35 hours of agency used between January to May 2015.
- There were no dental nurse vacancies.

Medical staffing

- All cosmetic surgeons worked for The Hospital Group. Other consultants such as anaesthetists and bariatric surgeons worked for the NHS but were contracted by The Hospital Group.
- All cosmetic and bariatric surgeons working at Dolan Park Hospital were registered with the General Medical Council (GMC). Doctors must be registered with a licence from the GMC in order to practise medicine in the United Kingdom.
- The hospital manager told us that all doctors had been re-validated by the GMC. This meant that patients were protected and treated by doctors fit to practice.
- During our inspection we spoke to two doctors running outpatient clinics. The doctors said they had worked regularly at the clinic providing continuity of care to people using the services.
- The three dentists currently providing treatment were not employees but work with practising privileges, essentially renting the dental surgery and the staff. Each dentist specialised in the provision of different treatments including; dental implants and orthodontics. Their General Dental Council registration, Disclosure and Barring Services (DBS) check, hepatitis B status and professional indemnity cover were checked prior to them being able to work at Dolan Park Hospital.

Major incident awareness and training

- The hospital had an Emergency Procedures for the Failure of Utilities policy which outlined the aims, responsibilities and procedures in the event of an emergency. Areas covered included; water and electrical supply failure and any security incident.
- Staff told us they were aware of the procedure for managing major incidents such as fire safety incidents. However, the training records showed that staff had not completed their fire training. This meant that staff had not received the appropriate training to support patients in the event of a fire emergency.

Are outpatients and diagnostic imaging services effective?

Staff confirmed they had not received training on the Mental Capacity Act 2005. However, they felt confident about seeking consent from patients. Staff were able to explain benefits and risks in a way that patients understood. We found that consent forms in dental services were not always completed and were not always given a copy of their new consent form regarding additional treatment received.

Staff appeared competent to undertake their roles but said there were no systems in place for their competencies to be reassessed or checked and felt this was an area they would like to improve.

Evidence-based care and treatment was practiced in the department, and staff told us they worked in line with the hospital's policies and procedures.

There was evidence of good multidisciplinary working in the outpatients and dental department. Doctors, nurses and allied health professionals worked well together. The outpatients department was open from 8.30am to 5pm, Monday to Friday. Extra clinics were also scheduled in the evening and at the weekends to meet the needs of patients.

Evidence-based care and treatment

- Staff were aware of how to access policies and procedures within their departments.
- Local policies such as the management of aftercare were written in line with the British Obesity and Metabolic Surgery Society (BOMSS) guidelines. We observed staff using these during their consultations with patients.

- Staff followed "The Art of Adjustments with the LAP-BAND AP System" for clinical band assessments/ adjustments. We observed staffing referring to the guidelines during their clinics.
- The manager told us the hospital followed the British Association of Aesthetic Plastic Surgeons (BAAPS) consumer safety guidelines. BAAPS guidelines ensured patients had all the information required to make an informed decision and that they were aware of their surgeon. BAAPS also identified the patient's right to change their mind.
- The hospital manager had carried out an unannounced "walk around" in November 2014. We saw there were no areas of concern identified within the outpatient department by the hospital manager.
- There was a Radiation Safety Policy available on the intranet and this was up to date however guidance on testing dental x-ray equipment on the intranet was last reviewed in 2011.
- Dental implant surgery audit (regarding failure rate) was not available at this service.

Pain relief

- We observed patients were asked if they were in pain during their appointment.
- Patients told us they were provided with pain relief when required.
- Staff could consult with the resident doctor for the management of pain when required.
- All prescriptions for pain relief were managed by the resident doctor.

Patient outcomes

- The data provided by The Hospital Group showed that the outpatient department saw over 12,000 patients between January 2014 and December 2014. Over 4,000 patients attended their first outpatient appointment and a further 8,000 were seen during their follow up appointments.
- The hospital did not have data which identified how many patients within the outpatients department were seen without full medical records being available.
- We saw assessments of people's needs were comprehensive and included the assessment of pain. We found that the outcome of treatment was being monitored and reviewed during each appointment.
- Doctors evaluated people's mood using the Hospital Anxiety and Depression Scale (HADS) to determine the level of anxiety and depression that a patient may be experiencing. This enabled them to outcome measure patients in the context of their anxiety and depression prior to surgery.
- The provider informed us that the dentists assessed and quality assured their own radiographs. This showed that in between January and May 2015, 25 of the 33 x-rays were graded as excellent and the remaining 8 as acceptable. However, guidance notes for dental practitioners on the safe use of x-ray equipment (Department of Health 2001) indicated that clinical audits and/or peer reviews of radiography must be provided. There was no evidence of audits being undertaken to monitor dental patient outcomes.

Competent staff

- We spoke with a trainee who had received corporate induction. They said they felt the information was very good and had helped them enormously.
- We saw a copy of the induction paperwork which staff completed. We observed nursing staff mentoring and providing support to trainee staff.
- Staff in the outpatients department told us that they had yearly appraisals. The records showed that the outpatient service was 100% compliant with their appraisals. Staff said that supervisions were not routinely carried out, but there was an "open door" policy and staff could request supervision at any time if they wanted to.
- Dental staff had taken part in an appraisal process however none of them occurred in the last 12 months.
- An allied health professional said they had monthly one to one development/feedback over the phone with their lead clinician.
- One staff member said there were no systems in place for their competencies to be reassessed or checked. They said this was an area which they felt they would like to improve.

Multidisciplinary working (related to this core service)

- There was evidence of good multidisciplinary working in the outpatients departments. Doctors, nurses and allied health professionals worked well together.
- Letters were sent out by the outpatients department to people's GPs to provide a summary of the consultation and any recommendations for treatment.
- Due to the nature of the dental services provided, patients referred themselves directly for treatment. If

however following a dentists assessment it was found that the patient was not suitable for cosmetic procedures, there was no onward referral to their local dentist regarding the findings and therefore may result in delays in receiving any recommended treatment.

Seven-day services

- The outpatients department was open from 8.30am to 5pm, Monday to Friday. Extra clinics were also scheduled in the evening and at weekends to meet the needs of patients.
- Staff said that consultant surgeons were available during the weekends and could be contacted out of hours.

Access to information

- Staff told us they had good access to patient related information and records whenever required. This meant that staff had access to the information which enabled them to care for patients appropriately.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were policies and procedures in place relating to consent, and the Deprivation of Liberty Safeguards (DoLS).
- Staff confirmed they had not received training on the Mental Capacity Act 2005. However, they were confident about seeking consent from patients. Staff were able to explain benefits and risks in a way that patients understood.
- We observed patients were asked for their consent to procedures appropriately. Staff gave patients the information they needed to make informed decisions about treatment.
- Patients told us that staff always asked for their permission prior to undertaking any procedures.
- We looked at seven records and saw that consent for the procedure had been completed and dates and signatures were legible.
- Staff told us that patients were given a copy of their consent form on receiving their care and treatment. This was confirmed with people spoken with. We saw that patients were asked to sign for any further treatment they received for example; adjustments to their gastric band. However, we observed that patients were not given a copy of their new consent form regarding additional treatment received. This meant that patients could not confirm accurately what further treatment they had received to support any queries they may have.
- In dental services 14 consent forms relating to patients currently receiving treatment were checked. We found that consent forms were not always complete. For example, 10 were not signed by the dentist and seven were not dated. Three of the consent forms were for an orthodontic treatment alternative to wearing braces. This dedicated document did not contain a prompt for the dentist to sign the form; however this only accounted for three of the consent forms that were seen.
- We observed one patient receiving dental treatment, treated without proof of valid consent being available.
- Dental services did not comply with the hospital consent policy (BC17) which stated that consent forms should be signed by the patient and healthcare professional and a copy should be given to the patient and the other copy remain in the healthcare records. We saw that copies of dental consent forms remained in records and staff confirmed copies were not provided to the patient.
- Dental services were not included in the consent audit that took place at the hospital in December 2014 as this included patients that needed to stay in overnight. There was no evidence of a consent audit taking place within dental services.

Are outpatients and diagnostic imaging services caring?

Outpatient and dental services were delivered by hardworking, caring and compassionate staff. We saw numerous examples of patients being treated with dignity and respect, and given compassionate care. Patients told us that doctors, nurses and allied health professionals answered their questions, and kept them informed of their care and treatment. We saw that patients were given information about their treatment, and gave consent prior to any treatment.

The reception area was an open space where people passed before going to the outpatients waiting area. We observed that patients could be overheard when they were

disclosing personal information. In addition, the clinical rooms were not soundproof, and so conversations could be heard by other people. This could compromise the privacy of patients.

Compassionate care

- Throughout our inspection we saw patients being treated with dignity and respect.
- Vulnerable patients, such as those who were living with a disability and/or complex health needs were treated sensitively and compassionately.
- All consultations took place in a private room to protect patients privacy.
- We observed good interaction between a patient and the consultant during a three month follow-up appointment. We saw the consultant explained everything to the patient and gave guidance regarding the clothing to wear to support the surgery undertaken.
- Receptionist spoke to patients in a polite way when attending for their appointment.
- All staff spoke with pride about their work, including those who were working in difficult circumstances.
- Most patients spoke positively about the care provided by staff. One patient said staff were "helpful and friendly." Another said the care was "fantastic." One patient said the care coordinator was "superb." They were available to allay any fears and was at the end of the phone to answer any queries.
- A patient that we spoke with was pleased to have always seen the same staff, including the dentist for treatments over the last six months.
- During dental treatments patients were regularly checked to ensure they were comfortable, particularly when a local anaesthetic had been given.
- Patients talked about the dental services being recommended by friends and family who had attended and received treatments previously. On display in the consultation room were a selection of thank you cards received by the dental team by patients, though compliments were not captured formally.

Understanding and involvement of patients and those close to them

- We observed staff explaining procedures to patients to help them to understand and be involved in decisions concerning their treatment.
- Patients told us they were given appropriate information in a way they could understand, and this helped them to be make decisions.
- Patients spoken with were aware of why they were visiting the outpatient and dental department.
- The outpatients department had patient questionnaires available to ask people what they thought of the service.
- We saw people completed a comment book held in reception. Examples of entries included; "wonderful staff, very friendly and 100% courteous." Another said; "fabulous service, brilliant staff." However, we found that patients also provided their personal details which included their address. We saw these could be read by all people visiting the hospital. This could affect the privacy of patients.
- Staff explained procedures to patients and gave them time to absorb the information given.
- Dental patients stated that they had been fully informed regarding care and treatment options and that they did not feel rushed or pressured to make decisions. The costs of treatment options were also included in these decisions.
- Dental patients reported that the aftercare was also described as very good, with information cleaning materials and instructions being provided.

Emotional support

- Staff said they were all sensitive to the emotional needs of a patient wherever possible. For example, one patient said they had panicked at the last minute and they found staff to be very supportive and reassuring.
- Patients were positive about the support they received from staff within the outpatients department.

Are outpatients and diagnostic imaging services responsive?

Staff told us that the service was flexed to meet the needs of patients. The organisation of the clinics was responsive to the needs of patients. Most patients were seen on time and patients said the service was quick and efficient.

There were information leaflets available in the reception area which provided patients with information on the services available. An interpreting service was available when required.

Outpatients and diagnostic imaging

There was no clear system in the outpatients department for staff to learn effectively from complaints.

Service planning and delivery to meet the needs of local people

- Staff told us that the service was flexed to meet the needs of patients. We observed during our visit two patients who had phoned requesting an appointment being seen the same day. Staff said they were able to adapt their appointments to accommodate extra patients which did not impact on the service provided.
- A staff member told us they were "here for the people attending the clinics" and that their aim was to provide "the best service we can."
- The patient care coordinators supported patients throughout their time with Dolan Park Hospital. They supported the patient from their initial consultation, through surgery to their post-operative care. Patients told us the care coordinator was "invaluable" and they could contact them with any query or concerns they may have.

Access and flow

- During our inspection, we saw most clinics running on time. Staff told us they were given 20 minute "slots" which they found, on occasions, difficult to manage due to the complexity of the patients seen.
- Staff followed the management of aftercare procedures following surgery. This focused on patients receiving a nurse call after two to five days followed by a dietician call within two to three weeks post-surgery and had a face to face consultation at five weeks. Patients' records showed they were assessed and reviewed by dieticians.
- One patient said they were provided with poor advice by a dietician after not being able to swallow food or drink over a number of days. Another said they had not received a follow up call by the dietician. However, we saw that both patients had been allocated appointments the same day to address these concerns.
- Patients requiring a band assessment and possible adjustment were seen five weeks post-surgery followed by fortnightly contact with either the dietician or nurse. Patients were seen up to 20 to 26 weeks dependant on their needs. After this time period patients were provided with a telephone contact for the weight loss surgery support team member to arrange further dietician or band adjustment appointments. There were clear guidelines for staff regarding the recording of the follow-up pathway.
- The hospital did not have a waiting list and said patients were seen within five weeks of their surgery. This was in line with the follow-up pathway guidelines. Patients spoken with said they had been seen within the allocated time and had no issues or concerns.
- We asked the manager of the outpatients department what the cancellation figures were but they were unable to give us this information.
- We reviewed the "did not attend" (DNA) rates between February 2015 and May 2015. These showed that 23% of people did not attend their first consultation and a further 19% did not attend their second consultation. However, the hospital did not have DNA rates for people not attending their post-operative appointments. Staff said they noted the absence on the electronic system and phoned the patients to arrange another appointment.
- We observed patients attending their appointments being booked in at the reception. We saw most patients were seen in a timely manner.
- During our visit we saw two patients waiting for over an hour for their appointment. The reception staff did not update patients the reason for the delay. One patient said they had been "slotted" into an appointment and was more than happy to wait. Another patient was using the facilities when their name was called. As a result another patient was seen instead. We heard the receptionist apologise to the patient.
- We spoke with seven patients waiting to attend clinics in the waiting room of the outpatients department. All the patients said that contact from the hospital following surgery was quick and follow-up appointments were prompt.

Meeting people's individual needs

- The provider had produced literature to people accessing the service. This meant they had a good understanding of the service being provided. This could be requested, when required, in a different language or format.
- The provider had access to interpreting and translation services from which they could arrange both face to face and instant telephone interpreting, document translation and British sign language services.

Outpatients and diagnostic imaging

- Staff told us that should a patient have communication problems they were able to address their individual needs. For example, staff said they conversed with a deaf patient by e-mails or text messages.
- Dental staff did not recall having to access translation services, but felt confident that they could arrange this for patients who did not have English as their first language via information on the hospitals intranet.
- We observed that the drinks machine within the reception area was inaccessible to people in wheelchairs. This meant that those people were dependent on others to get them drinks if needed.
- Staff said they were able to accommodate people's religious needs both pre and post operatively. They said they could contact the local community that offered support for example, church, mosque, temple or synagogue.
- Patients were given the contact details of the care co-ordinator who could be contacted at any time with any queries or to arrange access for an urgent appointment. A dental patient that we spoke with confirmed that they had often emailed the care co-ordinator to rearrange appointments. Early evening and Saturday morning appointments were made available.
- The care coordinators role included booking the appointments in the diary. Set amounts of time were allocated for each procedure.
- Patients told us the hospital accommodated their every need. One patient said they had a car pick them up and take them home after their appointment.
- Access to the dental department was via steps however an alternative entrance was available if patients had limited mobility.
- The services available were portrayed on posters together with literature on display within the reception area. We saw a showcase cabinet with a sample of products which included; support bras, corsets and special portion sized plates.
- Information on the services provided was also available on their website.

Learning from complaints and concerns

- There were 10 complaints reported between January 2014 and December 2014 with four further complaints in January 2015. Areas identified included concerns about the treatment received for gastric band surgery and breast augmentation following surgery.
- The manager told us they reviewed all complaints to review themes and trends. They said these were cascaded to staff where appropriate. We saw an outline of the complaint themes and actions taken. For outpatients care the complaints related to; aftercare, communication and support. We saw a memorandum to care coordinators ensuring they informed patients during consultation appointments of discharge and follow up procedures.
- Staff said they were aware of the complaints procedures. However, they said they had not received feedback from complaints. This meant there was no clear system in the outpatient department to learn effectively from complaints.
- Two patients said they had been given information on how to make a complaint from the receptionist. They said they knew how to complain to the hospital if they needed to.
- We saw that the literature provided to patients outlined the complaints procedure.
- Dental staff were not aware of any complaints from patients regarding dental services. There was information provided for patients about the complaints procedure on the cosmetic dentistry plan and personal quotation form however this was in quite small print and was not prominent.

Are outpatients and diagnostic imaging services well-led?

Although staff were aware of the hospital's mission and values they were unable to identify any actions/ developments to improve the service.

Not all risks within outpatient and dental services had been identified and highlighted on the risk register with action taken to mitigate the risk. The service held clinical governance meetings but these had recently been suspended and were due to recommence in June 2015. There was no dental representative at governance and risk meetings or on the Medical Advisory Committee. This meant there was not an effective system in place to report and learn from risk at team, management and organisational level.

There was a positive culture in the departments; staff were committed and proud of their work. Staff supported each other and there was good multidisciplinary team working

within the departments**.** Staff told us they were able to speak openly about any issues, that the provider was very visible and proactive and felt this was positive for making improvements to the service.

There were clear management structures in place within the outpatient's service but not within dental services.

There was no evidence of mandatory training records being kept up to date at a local or provider level.

There was a lack of audits in the outpatient department. Patients said they were seen within five weeks of their surgery. Management said they did not monitor the number of patients who did not attend their post-operative appointments. This meant the hospital could not measure the timeliness of appointments and monitor the care and welfare of people who used the service. We saw the hospital reviewed the patient satisfaction survey. However, we saw that the percentage (2%) was low and therefore the hospital could not effectively identify and monitor the service outcomes. Management were aware of the shortfall and told us they were looking at ways to capture this.

Vision, strategy, innovation and sustainability and strategy for this this core service

- We saw posters in the staff room showing the hospital's values and mission which was to provide an excellent patient experience. The provider's values outlined how they would work as a team whilst embracing improvement within the service by treating patients with empathy and promoting success by recognising individual and team achievements. Staff said that the hospital's values were discussed during their appraisals.
- Staff said they were unaware of any actions or developments to improve the service within the outpatients department.

Governance, risk management and quality measurement for this core service

- The manager said there was not a specific risk register for the outpatients department. Risks were not always appropriately identified, monitored and actioned by the hospital through their overarching risk register. Risks such as inaccurate staff training records were not highlighted.
- The governance and risk committee met quarterly, however one of the clinicians had been on sick leave and the meetings had been deferred until June 2015.
- We saw the annual governance and risk newsletter for April 2015. This included for example, information on how to report an incident and what to do should the fire alarm be activated.
- The manager and nurses we spoke with were unable to identify any audits to measure performance in the outpatient department. This meant that it was difficult to measure clinical performance and variations in service.
- Management said they did not monitor the number of patients who did not attend their post-operative appointments. This meant the hospital could not measure the timeliness of appointments and monitor the care and welfare of people who used the service.
- Senior staff had access to governance systems that enabled them to monitor the quality of care provided. This included the provider's electronic incident reporting system and staff training records.
- There was no evidence of mandatory training records being kept up to date at a local or provider level. There was a reliance on being informed via human resources when training was due. This meant that staff were at risk of not receiving appropriate training because the provider did not have accurate records.
- The feedback from patients was not consistent across the service. Staff told us they were aware of the lack of feedback and were looking at ways of increasing patient involvement.
- Staff said they received annual appraisals and data supported this.
- There was no dental representative at governance and risk meetings or on the Medical Advisory Committee.
- There was no evidence of incident reporting related to patients and no risk register entries related to dental services, such as clinical waste or Legionella risks.

Leadership/culture of service

- Staff told us they felt supported by their manager in the outpatient department. They felt listened to and that the manager would act on their behalf and look after their best interests. Some staff felt that communication was not always filtered down to the outpatients department.
- There was little evidence of information being sent to senior managers within the organisation other than to the managers of the units and staff told us that they "do not hear or see any managers other than unit managers".

Outpatients and diagnostic imaging

- Staff said they did not have any formal staff meetings or the opportunity to get together as a hospital wide team. They said most of their contact was through e-mail. This meant that staff were not given the opportunity to discuss any issues or concern with their colleagues or the provision for feedback or lessons learnt on relevant topics for example, incidents and complaints.
- Senior managers attended a weekly meeting. However, there were no minutes taken of these meetings. We were informed that one of the senior managers would interpret the recorded notes and identify key actions agreed. We saw copy of the meeting's agenda which identified hand written entry outcomes of the meetings. This meant that establishing a clear audit trial to ensure all actions had been completed was difficult.
- There was no evidence of mandatory training records being kept up to date at a local or provider level. There was a reliance on being informed via human resources when training was due. This meant that staff were at risk of not receiving appropriate training because the provider did not have accurate records.
- Dental services used to employ a dental manager responsible for the service, but the post has not been recruited to for over a year. There was a lead dental nurse appointed in March 2015 based in Newcastle, who described their main responsibility was to oversee holiday cover and review and update the departments policies and guidelines. The nurse had visited the service twice since taking up the role. The remit of managerial responsibilities for dental services were unclear. For example, the lead dental nurse did not have an overview of how many staff had completed their mandatory training.
- Some staff said the provider was very visible and proactive. They said they were provided with a lot of information by e-mail.
- Staff were very enthusiastic and felt valued and listened to. They said they loved their role.

Culture within the service

- We found a positive culture in the outpatients department. Staff were committed and proud of their work.
- Staff said they worked well as a team and supported each other.
- Staff shared their views about the service openly and constructively. They were caring and passionate about the service and the care they provided to people who use the service.

Public and staff engagement

- Staff we spoke with said they were able to voice their concerns should they need to.
- Members of the public were invited to leave comments about the service they had received in a book left in reception. However, we saw the information provided was not confidential as it included people's names and addresses. This meant that people's personal information could be read by other people visiting the service. This had not been highlighted on the risk register.
- There were 6905 outpatients discharged from Dolan Park Hospital during 2013/14. Of those patients a total of 145 (2%) had completed and returned a patient satisfaction survey. Of these 145 completed patient satisfaction surveys 25 (17%) were returned from patients who attended Dolan Park Hospital's outpatient clinic. Patients said that that staff were "lovely" and "very attentive."
- Staff told us they were aware of the shortfall in obtaining feedback and were looking at ways to capture this.
- Feedback from dental patients was not actively sought. Staff were aware that the hospital conducted patient satisfaction surveys but they did not receive any feedback.
- There was information about the services on the provider's website.
- Information was sent to staff regularly by e-mail. Staff were encouraged to look at the staff intranet.

Innovation, improvement and sustainability

- We did not see any evidence of the development of the service from management. The manager was unable to provide details of clear goals for the future development of the service in order for it to continually innovate, improve and sustain performance in the long term.

Outstanding practice and areas for improvement

Outstanding practice

- Excellent multidisciplinary working across the hospital, to ensure that patients received appropriate and timely care.
- A caring and responsive approach to patients after their surgery.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that all equipment used by the service is clean and properly maintained.
- Ensure there are up to date records to demonstrate that a robust system is in place to maintain equipment.
- Ensure the disposal of teeth (including those containing amalgam fillings) follows the waste segregation regulation Health Technical Memorandum 01-07.
- Ensure staff understand the principles and codes of conduct associated with the Mental Capacity Act 2005.
- Ensure consent forms are accurately completed.
- Ensure effective systems are in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users, including ensuring that the risk register is reflective of service risks.
- Ensure that staff mandatory training records are accurate.
- Ensure that dental services have a clear leadership structure and has representation at governance and risk meetings and/or on the Medical Advisory Committee.
- Ensure all medicines are managed and stored safely and securely to prevent theft, damage or misuse, including Controlled Drugs.
- Ensure the provider has a service level agreement in place to ensure timely care planning can take place to ensure the health, safety and welfare of the service users that require transfer to a NHS hospital.

Action the hospital SHOULD take to improve

- Ensure all incidents are recorded and staff receive feedback and learn from incidents.
- Ensure staff are aware of the new duty of candour regulations (where people who use services are told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result).
- Ensure a system is in place to analyse arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs.
- Ensure all staff use hand sanitiser gel before entering the theatre area.
- Ensure that staff receive formal supervision, appraisals and appropriate competencies.

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 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: The provider did not ensure that all equipment used by the service provider was clean or properly maintained; the provider did not maintain standards of hygiene appropriate for the purposes for which they were being used. During the inspection we found equipment to be dusty on the surgical wards and found dust within the outpatient department. This meant that equipment were not always adequately clean to prevent the spread of infection through the build-up of dust. Despite procedures being in place to check equipment we found equipment in surgery that had passed service dates, including all three ward defibrillators. There were no up to date records to demonstrate that a robust system was in place to maintain equipment on the wards. There were no dedicated pots available for teeth that had been removed. Usual practice was to dispose of teeth (including those containing amalgam fillings) into the waste bags for contaminated clinical waste. This contravenes waste segregation regulation Health Technical Memorandum 01-07.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider did not ensure that care and treatment of service users must only be provided with the consent of the relevant person.

This section is primarily information for the provider

Requirement notices

We found no evidence of mental capacity training for staff. Staff did not know how to assess mental capacity. This meant that staff who obtained consent of people who use the service were not familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005.

We found incomplete consent forms for 10 out of 14 relating to patients receiving dental treatment were checked. i.e. 10 not signed by the dentist and seven were not dated.

During the inspection a patient receiving dental treatment was treated without proof of valid consent being available.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider did not ensure the proper and safe management of medicines; the provider could not ensure timely care planning could take place to ensure the health, safety and welfare of the service users that required transfer. The outer medication cupboard in recovery, which also held Controlled Drugs behind a second cupboard, had been left open. First line medications were readily accessible via the first open cupboard. A lockable cupboard which stored anaesthetic medicines had been left unlocked in a store room in theatres. There were other medications other than those documented and audited within the dental services medication cupboard. This meant that systems were not in place to safely store and monitor all medications. Dolan Park Hospital did not have a formal service level agreement with an ambulance company or NHS hospital for transfer of patients. This meant that there was a risk patient treatment and care planning could be delayed because patients would need to go via an emergency department.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not operate effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. We found risks were not always identified, monitored and mitigated. For example: - Incident reports were not always completed - The Radiation Protection Advisor site report recommended a critical examination of the OPG (orthopantomogram, an x-ray image of the whole mouth) machine and quality assurance checks. There was no evidence during the inspection that this had been carried out. This information has been requested. This risk register did not reflect the risks staff reported to us or risks that we identified such as accurate training records or dental leadership. We found that staff reported they had received appropriate training but that human resource records did not support this. The senior management team recognised that the recording of mandatory training within the hospital was an issue and that the data did not always correlate with the training delivered and received by staff. They also acknowledged that there was no escalation to the governance and risk committee regarding poor mandatory training data. This meant that the provider did not have appropriated systems and processes in place that enables them to identify and assess risks.