

# InHealth Limited

## Quality Report

The Cardiac Unit  
St. Peters Hospital  
Guildford Road  
Chertsey  
Surrey  
KT16 0PZ

Tel: 01932 722262

Website: [www.inhealthgroup.com](http://www.inhealthgroup.com)

Date of inspection visit: 9 & 10 June 2015

Date of publication: 09/12/2015

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We inspected InHealth Ltd “The Cardiac Unit at St Peters Hospital” on the 9th and 10th June 2015. This was a pilot comprehensive inspection to test our new methodology for inspecting diagnostic and endoscopy services; we therefore did not rate this service.

The cardiac interventional and electrophysiological service at Ashford and St Peter’s NHS Foundation Trust (the ‘Trust’), on the St Peter’s Hospital site, was established by tender as a managed service partnership between InHealth Ltd and the Trust in 1998.

In 2012 the Trust tendered for a replacement contract requiring construction of two co-located cardiac catheter laboratories and a purpose built ten-bedded day ward and recovery area. InHealth was successful in tendering for this service resulting in the design, build and fitting of the facility which is the subject of this inspection.

InHealth Ltd. provides cardiac radiographers, cardiac nursing staff and patient administrators who worked with Trust employed cardiologists and cardiac physiologists. Initially, the case mix focussed mainly on angiograms and pacemaker procedures, but as patient numbers and clinical capabilities expanded, the service has evolved and now addresses the full range of cardiac interventional procedures including electrophysiology (EP) and pacing. The Trust engages 10 cardiologists.

The service delivers predominantly NHS funded care although carries out a small number of diagnostic and interventional procedures on privately funded patients. 66% of cases are carried out on patients aged above 65 years; the service rarely treats children but there were provisions in place for ensuring that appropriate support was available where the need arose for older adolescents to undergo diagnostic cardiac procedures. Where patients required continuing care following their diagnostic or interventional procedure, they were transferred back to the care of Ashford and St Peter’s NHS Foundation Trust.

### Are services safe at this service

- Staff had a basic understanding of the duty of candour in that they were required to be open and transparent when things went wrong. However, improvements were required to ensure that the provider has systems in place to ensure that the local arrangements met with regulatory requirements including how patients were kept informed of investigations.
- The service was visibly clean and staff were witnessed to follow appropriate infection control practices. Audits were routinely undertaken to ensure staff complied with local and national policies and action was taken if areas of concern were identified.
- Whilst the provider had a local policy for the reporting and management of incidents, staff were not always aware of their roles and responsibilities with regards to the reporting of incidents; there was an inconsistent approach to how incidents were reported with staff using two different systems or relying on the registered manager to report incidents on their behalf.
- There were appropriate arrangements in place for ensuring that patients and staff were protected from the risk of harm associated with the use ionising radiation.
- Whilst no specific nursing acuity tool was used, the approach to planning staffing was carried out based on the needs of patients.

### Are services effective at this service

- Staff based care on best practice guidance. A robust clinical audit programme was in place to demonstrate that action was taken and outcomes monitored to determine effectiveness where improvements were needed. The service benchmarked itself against a range of national comparators; this demonstrated that the service generally performed the same as, or better than others in many areas.

# Summary of findings

- Further work was required to ensure that a robust audit programme existed which assessed the effectiveness of and the quality of nursing care provided by the service.
- Multidisciplinary working was strongly embedded across the service and neighbouring NHS Trust.

## **Are services caring at this service**

- There was a strong emphasis on providing caring, compassionate and dignified care to patients. Feedback from patients was consistently good; patients felt involved in their care and were supported to make decisions based on the support from nursing and medical staff.

## **Are services responsive at this service**

- The service was able to assess and respond to the needs of the population they served. Feedback was gathered from patients and relevant stakeholders to enhance services. This included the introduction of a pPCI service in conjunction with local commissioners and the local NHS Trust.
- Staff were aware of the basic needs of patients living with dementia however it had been recognised that further training was required to ensure that the needs of patients could be fully met.
- Waiting lists were in the main, well managed. Patients could expect to be offered appointments in line with local and national requirements.
- Complaints were acknowledged and managed in line with local policies. The provider liaised with the commissioning NHS Trust when complaints involved components of care which had been provided across a range of services. There was evidence that changes took place as a result of complaints being received including some adjustments to the environment.

## **Are services well led at this service**

- Whilst the provider had an organisation wide quality improvement strategy, this was not fully embedded at a local level. Staff were not fully aligned to the strategy and there was some confusion amongst staff on how they could attain level 3 accreditation with the “InHealth Way” quality improvement initiative.
- The morale and culture of the service was one where staff went “The extra mile” to ensure that patients received high quality care.
- Improvements were required with regards to how risks were managed. There was some inconsistency with the recording and management of risks, specifically related to staffing the proposed pPCI service and how incidents were reported and managed.

There were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Review the existing governance arrangements to ensure that staff report incidents in a standardised way, utilising the provider’s standard incident reporting system.
- Review the existing risk management strategies and arrangements to ensure that risks relevant to the service are recorded on the local risk register and escalated to the senior executive team in line with internal policies and procedures.

In addition the provider should:

- Consider reviewing its existing audit programme to ensure that where recommendations are made, action is taken to address areas which could lead to improvements in the quality of care that is delivered to patients.
- Consider reviewing the staffing establishment prior to the commencement of the pPCI service to ensure that there are sufficient numbers of nursing and radiography staff with the relevant skills and competence to support the proposed on-call rota whilst also sustaining the elective day-case workload.

# Summary of findings

- Consider reviewing the environment to ensure that relatives can be present to support those patients who are anxious or nervous prior to and after their procedure.
- Consider reviewing the existing parking arrangements so that patients who have undergone diagnostic or interventional procedures can be collected more easily.
- Consider reviewing the signage to the cardiac unit so that it is easier for patients and visitors to find the unit.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

## Overall summary

Staff were found to be caring and responsive to patient's needs. Clinical outcomes were seen to be in-line or better than national performance in a range of areas.

The environment was well maintained and generally fit for purpose; there were systems in place to protect patients from the risk of infections. Processes and procedures were in place for ensuring that the risks associated with the use of ionising radiation were managed appropriately and in line with national requirements.

Services were organised so that they met the needs of the local population however further work was required to ensure that staff had the necessary skills and experience to manage patients living with dementia; this had already been acknowledged as an area which required improvement by the provider.

Improvements were required in a range of areas including how incidents and risks were reported and managed. There was an inconsistent approach to how staff reported clinical incidents and there was some discrepancy amongst staff with what constituted a reportable incident.

Nursing and radiology staffing levels were, in the main, found to be sufficient. Whilst the service did not utilise a formal patient acuity tool to determine staffing levels, the local management team reviewed and assessed staffing levels on a regular basis to ensure the needs of patients could be met. Where temporary bank and agency staff were required, induction programmes were in place to ensure individuals were orientated to the service as well as there being a process in place to determine the competency of individuals to ensure they had the right skills and knowledge to care for patients receiving care in this specialist environment.

# Summary of findings

## Our judgements about each of the main services

### Service

#### Diagnostic Imaging and Endoscopy Services

### Rating Summary of each main service

Staff were found to be caring and responsive to patient's needs. Clinical outcomes were seen to be in-line or better than national performance in a range of areas.

The environment was well maintained and generally fit for purpose; there were systems in place to protect patients from the risk of infections. Processes and procedures were in place for ensuring that the risks associated with the use of ionising radiation were managed appropriately and in line with national requirements.

Services were organised so that they met the needs of the local population however further work was required to ensure that staff had the necessary skills and experience to manage patients living with dementia; this had already been acknowledged as an area which required improvement by the provider. Improvements were required in a range of areas including how incidents and risks were reported and managed. There was an inconsistent approach to how staff reported clinical incidents and there was some discrepancy amongst staff with what constituted a reportable incident.

Nursing and radiology staffing levels were, in the main, found to be sufficient. Whilst the service did not utilise a formal patient acuity tool to determine staffing levels, the local management team reviewed and assessed staffing levels on a regular basis to ensure the needs of patients could be met. Where temporary bank and agency staff were required, induction programmes were in place to ensure individuals were orientated to the service as well as there being a process in place to determine the competency of individuals to ensure they had the right skills and knowledge to care for patients receiving care in this specialist environment.

# Summary of findings

## Contents

### Summary of this inspection

	Page
Background to InHealth Limited	8
Our inspection team	8
How we carried out this inspection	8
Information about InHealth Limited	9
The five questions we ask about services and what we found	10

---

### Detailed findings from this inspection

Outstanding practice	29
Areas for improvement	29
Action we have told the provider to take	30

---

# InHealth Limited - The Cardiac Unit

**Services we looked at**

Diagnostic Imaging (Cardiac catheter laboratory service)

# Summary of this inspection

## Background to InHealth Limited

In 2012 Ashford and St Peter's NHS Foundation Trust (the 'Trust') tendered for a replacement contract requiring construction of two co-located cardiac catheter laboratories and a purpose built ten-bedded day ward and recovery area. InHealth was successful in tendering for this service resulting in the design, build and fitting of the facility which is the subject of this inspection.

InHealth Ltd. provides cardiac radiographers, cardiac nursing staff and patient administrators as well as managed facilities in order that NHS funded care patients can undergo both diagnostic and interventional cardiac procedures; the service is supported by cardiologists who operate under the rules of practising privileges, whilst being employed by Ashford and St Peter's NHS Foundation Trust and other NHS trusts. Initially, the case mix focussed mainly on angiograms and pacemaker procedures, but as patient numbers and clinical capabilities expanded, the service has evolved and now addresses the full range of cardiac interventional procedures including electrophysiology (EP) and cardiac pacing.

The service provides cardiac diagnostic and interventional services to a population of around 410,000 people living in the boroughs of Runnymede, Spelthorne, Woking and parts of Elmbridge, Hounslow and Surrey

Heath. There are variations within those areas in terms of the ethnic diversity of the local populations and levels of deprivation. In Spelthorne and Runnymede the average proportion of Black and minority ethnic residents was 12.7% and 11% respectively, both lower than that of England of 14.6%. The average proportion of black and minority ethnic residents in Hounslow was 48.6%, significantly higher than that of England (14.6%). Deprivation in all three areas was the same as the England average, but with higher-than-the-England average rates of children in poverty and statutory homelessness in Hounslow.

The service is registered to provide the following regulated activities, all of which are managed on a day-to-day basis by the registered manager, Mrs. Mumtaz Parker, who was registered with the Care Quality Commission on 16 January 2014:

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

The named controlled drug accountable officer is Mrs. Jackie Churchman who has been in the role since 2007.

## Our inspection team

Our inspection team was led by:

**Inspection Lead:** Nick Mulholland, Inspection Manager, Care Quality Commission

The team included two specialists including a senior lecturer radiographer and a senior theatre nurse. Whilst not present for the site visit, we also sought specialist advice from a national professional advisor both before and after the inspection.

## How we carried out this inspection

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

- Is it safe?
- Is it effective?

- Is it caring?
- Is it responsive to patients' needs?
- Is it well-led?



# Summary of this inspection

Prior to this inspection we reviewed a range of information we held about the provider and this registered location. We reviewed information from organisations that had shared what they knew about the provider; these included NHS England, Health Education England (HEE), The General Medical Council (GMC), The Nursing and Midwifery Council (NMC) and Royal Colleges.

We visited the location on the 9<sup>th</sup> and 10<sup>th</sup> June 2015 where we interviewed staff and managers, talked with

patients and staff and also with carers and family members of patients. We observed how people were being cared for and reviewed patients' records of personal care and treatment. We also reviewed information supplied to us by the provider and reviewed data that CQC holds on the provider and the registered location.

## Information about InHealth Limited

### Context

- A part of the Inhealth Group
- Two cardiac catheter laboratories
- Employs 6.8 whole time equivalent nursing staff, 3.8 wte radiographers, 3.1 wte health care assistants and 3.2 wte administrative and clerical staff. 10 consultant

cardiologists who are employed by Ashford and St Peters NHS Foundation Trust support the service and are managed by way of practising privileges which are held with individual consultants and InHealth Ltd.

### Activity

- Between January and December 2014, the service co-ordinated 4,441 attendances, of which, 66% consisted of people aged above 65 years.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

The threshold for reporting incidents was high amongst staff and safety concerns were not consistently reported. There was variable use of systems to record and report safety concerns, incidents and near misses. Some staff were not following local processes or the organisational policy on reporting incidents.

Care and treatment was provided in a well maintained and appropriate environment and the risks of infection were minimised. Equipment was maintained and checked to ensure it was functioning safely.

Whilst there was reliance on bank and agency staff to support the service, those staff who were used were familiar with the unit and had been competency assessed to ensure they had the relevant skills and knowledge to support patients in the cardiac catheter laboratory setting.

### Are services effective?

People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Clinical outcomes were monitored to ensure consistency of practice however further work was required to ensure that the quality and effectiveness of nursing outcomes were monitored and actions taken where improvements were required.

There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking, peer review and service accreditation. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff.

### Are services caring?

There was positive feedback from patients and those close to them about their experience of care and treatment. Patients were treated with kindness and relationships with staff were positive. Patients were supported to make their own decisions and were supported to understand their care and treatment and staff provided emotional support to assist patients to cope with their treatment.

### Are services responsive?

Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and

# Summary of this inspection

continuity of care was reflected in the service. Further work was required to ensure that laboratory utilisation rates and “Did not attend” rates were reviewed to ensure the service was as responsive as it could be.

Signage to the unit was not as good as it could be which led to complaints from patients; the provider was working with the commissioning NHS trust in an attempt to resolve this issue alongside issues with short stay car parking.

## Are services well-led?

The organisations vision and values were not fully embedded within the service; there was confusion amongst staff with regards to the “Inhealth way” accreditation system,

The arrangements for governance and performance management did not always operate effectively; risk registers were not always effectively used so it was not possible to determine what oversight specific risks had nor was there evidence of how some risks were being effectively managed. Staff raised concerns with the proposed introduction of a formal 24/7 primary percutaneous coronary intervention service as there was insufficient nursing and radiology staff to support the service. This had been identified by the provider as part of the initial business case and recruitment was continuing although it was unclear how the provider was intending to robustly mitigate the risk to patients upon the introduction of the service.

The local leadership was seen to be approachable and there was a “Can do” attitude where staff went “The extra mile”. Relationships between the provider and the main commissioning NHS trust was good and there was engagement with professionals from both organisations with regards to the oversight of risks.

## Detailed findings from this inspection

# Diagnostic Imaging and Endoscopy Services

Safe	
Effective	
Caring	
Responsive	
Well-led	

## Information about the service

The Cardiac Unit at St Peters Hospital is provided by way of a tender agreement between InHealth Ltd and Ashford and St Peters NHS Foundation Trust. The service provides a range of diagnostic and interventional cardiac services including, but not limited to coronary angiograms, coronary angioplasty, electrophysiological studies and/or ablations, insertion of pace makers and internal cardioverting defibrillators as well as the carrying out of external cardioversions.

At the time of our inspection, the location was preparing to commence the provision of a primary percutaneous coronary intervention services 24 hours per day, seven days per week; this service was scheduled to commence in July 2015.

## Summary of findings

Staff were found to be caring and responsive to patient's needs. Clinical outcomes were seen to be in-line or better than national performance in a range of areas.

The environment was well maintained and generally fit for purpose; there were systems in place to protect patients from the risk of infections. Processes and procedures were in place for ensuring that the risks associated with the use of ionising radiation were managed appropriately and in line with national requirements.

Services were organised so that they met the needs of the local population however further work was required to ensure that staff had the necessary skills and experience to manage patients living with dementia; this had already been acknowledged as an area which required improvement by the provider.

Improvements were required in a range of areas including how incidents and risks were reported and managed. There was an inconsistent approach to how staff reported clinical incidents and there was some discrepancy amongst staff with what constituted a reportable incident.

Nursing and radiology staffing levels were, in the main, found to be sufficient. Whilst the service did not utilise a formal patient acuity tool to determine staffing levels, the local management team reviewed and assessed staffing levels on a regular basis to ensure the needs of patients could be met. Where temporary bank and agency staff were required, induction programmes were in place to ensure individuals were orientated to the

# Diagnostic Imaging and Endoscopy Services

service as well as there being a process in place to determine the competency of individuals to ensure they had the right skills and knowledge to care for patients receiving care in this specialist environment.

## Are diagnostic imaging and endoscopy services safe?

The threshold for reporting incidents was high amongst staff and safety concerns were not consistently reported. There was variable use of systems to record and report safety concerns, incidents and near misses. Some staff were not following local processes or the organisational policy on reporting incidents.

Care and treatment was provided in a well maintained and appropriate environment and the risks of infection were minimised. Equipment was maintained and checked to ensure it was functioning safely.

Whilst there was reliance on bank and agency staff to support the service, those staff who were used were familiar with the unit and had been competency assessed to ensure they had the relevant skills and knowledge to support patients in the cardiac catheter laboratory setting.

## Incidents

- There were no reported never events for this service. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systematic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- We spoke with nine members of staff who were able to describe the process for reporting incidents, accidents and near misses. Staff described two separate incident reporting systems, Datix© and Sentinel©. We identified that there was a disparity between the process for incident reporting in that some staff routinely used Datix whilst others used Sentinel. Some staff had previously been employed by the NHS trust who utilised Datix as their main incident reporting system and so on migration to InHealth Ltd, staff had continued to report incidents utilising the Datix system. We found that whilst there was a good relationship between the registered manager of InHealth Ltd and the general manager employed by the NHS Trust which meant that incidents reported on to Datix were shared between the two providers, staff

# Diagnostic Imaging and Endoscopy Services

were not following the InHealth Ltd policy with regards to incident reporting. Incidents which were reported on Datix and/or Sentinel were discussed during joint clinical governance meetings or via informal methods between the registered manager (InHealth Ltd) and the general manager (NHS Trust).

- Nursing and radiology staff informed us that they would routinely inform the registered manager if they had reported an incident on Datix. However, this led to there being a reliance on the registered manager to then obtain details of the Datix report from a trust representative, before then reporting the incident using the InHealth Sentinel incident reporting system. The practice of reporting incidents on the Datix system was contrary to the InHealth incident reporting policy (dated August 2013) which stated that “All incidents are recorded directly by the staff at InHealth clinical facilities... directly into the online Sentinel Reporting System”.
- The service reported 42 incidents between June 2014 and March 2015. We discussed the incident reporting rate with the Chief Executive who considered that overall, the rate of incident reporting was considered to be good although there had been no comparable benchmarking with similar services to determine if this was the case. It had been acknowledged in the Providers Quality account for 2012/2013 that the rate of incident reporting was below the expected total numbers and that further work was required to ensure that staff reported all incidents.
- As is required by the Care Quality Commission (Registration) Regulations 2009, the provider notified the Care Quality Commission of four incidents which met the criteria of being a “Statutory Notification”. One incident related to the unexpected death of a patient within 30 days of receiving treatment, one related to the death of a patient during a procedure and one incident involving the police whereby the keys for the controlled drug cupboard had been lost (we received an initial notification on 22 October 2014, followed by an update notification on 23 October 2014); the reported actions taken by the provider in relation to

the incident involving the lost keys were considered to be appropriate and included relocation of the controlled drug stock to another secure cabinet, referral to the police and an internal investigation.

- There was evidence that the incident which related to the death of a patient during a cardiac procedure had been referred to the Coroner and lessons learnt were disseminated to staff as part of a formal de-briefing exercise following the incident. The staff we spoke with were able to describe the incident and the actions they had taken subsequently. The incident had been reported on Sentinel and had also been discussed at the clinical governance meeting facilitated by Ashford and St Peter’s NHS Foundation trust.
- There was a process for ensuring that cases which resulted in death or significant morbidity were reviewed by a senior cardiac clinician to determine any quality-in-care issues and to ensure that treatment pathways and clinical decisions were appropriate. Outcomes of morbidity and mortality reviews were discussed at local team meetings to ensure that cases could be discussed and lessons learnt and disseminated amongst the team.

## Duty of candour

- Whilst staff were able to describe the basic concept of the duty of candour as being “Open and transparent”, there was little understanding with regards to the formal regulatory requirements. The provider did not have a policy in place to support staff with regards to the implementation of the duty of candour. When things had gone wrong there was evidence that patients had been offered mediation sessions with the manager however there was no evidence that patients had been kept informed of any remedial action that was taken following significant events.

## Cleanliness, infection control and hygiene

- Representatives from the Ashford and St Peter’s NHS Foundation trust conducted routine infection control audits to ensure the clinical area within The Cardiac unit was sufficiently clean and maintained. We found that as a result of an audit conducted in March 2015 (overall audit result of 92%), changes to the

# Diagnostic Imaging and Endoscopy Services

environment and amendments to policies had taken place to ensure the service was complying as far as was reasonably practicable with local and national infection prevention and control guidance.

- The service was subject to annual health quality audits; this had last been conducted on 17 April 2015. Overall performance with infection control policies was seen to require some improvement at the time of the audit; it was noted that sharps bins were being stored on the floor in the catheter laboratory; we found that sharps bins had since been moved and were secured in mobile wheelie holders. Action had also been taken to resolve storage issues which had been identified as part of the audit; this included consumable medical equipment being stored on the floor which again had been resolved at the time of the inspection.
- The vast majority of surgical instruments used were “single-use only” minimising the risk of cross-infection. We looked at patient records and saw that the packaging for these was retained thus ensuring traceability of instruments used.
- We spoke with three members of nursing staff who were able to describe the procedure for managing spillages of bodily fluids.
- We saw there were appropriate hand-washing facilities at the service. We saw that adequate supplies of hand sanitiser were available throughout the service, including patient areas such as reception. We saw staff decontaminating their hands appropriately.
- There were cleaning schedules for the treatment areas. We saw checklists that were consistently completed showing that this schedule had been complied with.
- Regular hand hygiene audits and compliance with “Bare below the Elbow” policies were carried out. We reviewed the audit results dating between January and May 2015; compliance of around 98-99% was consistently achieved. Where staff had been observed to not be abiding by the local hand hygiene policy, the auditor noted conversations that they had with staff as a means of educating staff on the importance of ensuring they abided with local policies in order to protect patients.
- The service commissioned external agencies to conduct water safety testing assessments including the screening for and management of Legionella. A legionella risk assessment and water hygiene review had been carried out on 3 September 2014; the service was identified as scoring a risk score of 60% and a range of recommendations had been made including the descaling of taps and the introduction of robust monitoring systems; these actions had been undertaken at the time of our inspection.
- There was evidence that the water system had last been disinfected on 20 May 2015. Water samples were also tested for the presence of Pseudomonas; we found that laboratory results indicated Pseudomonas levels to be line with expected ranges.
- Water temperatures at outlets across the department were seen to be tested monthly.
- Equipment which had been cleaned following use had been labelled with green “I’m clean” labels; we reviewed ten pieces of equipment and found that they had been cleaned in the previous 24 hours.
- 75% of staff had completed their mandatory training in infection prevention and control.
- The provider reported no hospital acquired infections between January and December 2014.
- In the Q1 2015 Patient Satisfaction survey, 85% of patients reported that the cleanliness of the environment was excellent and 13% thought it was very good.

## Environment and equipment

- It was reported by members of the senior management team that existing arrangements for the regular servicing of medical equipment had not been sufficiently robust with a range of service agreements not being renewed. Prior to our inspection, we found that service agreements had been taken out with a range of providers to ensure that medical equipment was routinely serviced and maintained. An inventory had also since been created to ensure that the manager had oversight of when devices required servicing in line with manufacturer recommendations.



# Diagnostic Imaging and Endoscopy Services

We noted that two Philips© electrocardiogram (ECG) machines had not been serviced in the preceding twelve months; we observed staff using these machines within the cardiac day case area.

- Resuscitation equipment was available in each of the cardiac catheter laboratories and also in the ten bedded day case area. Resuscitation equipment was routinely checked by nursing staff and checklists were signed accordingly.
- We noted that packets containing gel based defibrillator pads in the cardiac catheter labs were opened; staff reported that this was to allow quick connection to patients in the event of an emergency. The pre-opening of these pads is not recommended by manufacturers as there is a risk that the gel based adhesive could dry out, therefore reducing the adhesion of the pads to the skin and impacting on the efficiency of the pads.
- Bedside suction and oxygen was available for patients; we observed staff checking these prior to the admission and following discharge of patients.
- We noted that four large oxygen cylinders were being stored in a blue crate which was located in the corridor; the crate was insufficiently robust to protect the cylinders from falling over; we raised this with the manager at the time of the inspection who took action to move the cylinders to a safe place.
- The service had access to a Radiation Protection Advisor (RPA) who was employed by a local provider. Annual radiation protection audits were carried out and encompassed a range of areas including quality assurance, local rules and radiation protection policies and procedures. Radiography staff reported that they had direct access to the RPA and contact details were seen to be accessible in the Cardiac Unit. The unit also had a named Radiation Protection Supervisor who acted as the local contact and co-ordination person for any enquiries regarding radiation protection.
- In addition to the local Radiation Protection Supervisor, staff could access a corporate Radiation Protection clinical lead who provided additional support and was generally the first contact for any radiation protection concerns or incidents. The clinical

lead was responsible for co-ordinating any investigations / Root Cause Analysis and reporting of any incidents reportable to CQC under Ionising Radiation (Medical Exposure) Regulations (IRMER).

- The local radiation protection rules were displayed at the entrance to the control room to the catheterisation laboratories and included contact details for both the RPA as well as the Medical Physics Expert at a local hospital. All staff were reported to have read the rules and a register of signatures was displayed in the manager's office to this effect.
- All related policies and protocols were held in the control room for easy access by all staff. Following a recent incident, a log book was created and held within the control room for any students / visitors to the lab to ensure the appropriate protocol was followed regarding health and safety while in the laboratory.
- Staff reported that the electrical equipment located in the cardiac catheter laboratories was not supported by an uninterrupted power supply and so in the event of an unplanned electricity outage, there would be no live stream of images and the main x-ray system would require a re-boot which was reported to take approximately 5-7 minutes. There had been one reported power outage in the preceding 6 months. Staff were aware of the risk assessment that had been developed and the manager had raised an enquiry with the manufacturer of the imaging system to determine whether a solution could be sourced. Nursing, medical and radiology staff advised that in the event of a power outage, any procedures would be suspended, reassurance provided to the patient and the procedure recommenced once the imaging facilities were active again.
- The radiology team were aware that the roof to the building which housed the laboratory was not lead lined and so was designated as a controlled area. Access to the area was by way of a key; a local operational procedure was in place which meant that access was not permitted when the laboratories were in use. Additionally, X-ray warning lights were fitted to the entrance to the plant room access door and these were checked regularly to ensure they were functioning.

# Diagnostic Imaging and Endoscopy Services

- Patient dose surveys were conducted and sent to the local Radiation Protection Advisor for consideration and action was taken where deviations in diagnostic reference levels had been noted.
- There was a process for the screening of and replacement of lead aprons; bi-annual inspections of lead aprons took place and the findings were fed back to the provider wide radiation protection committee.
- In the Q1 2015 Patient Satisfaction survey, 86% of patients reported that the standards of the facility were excellent, 13% very good and 1% good.
- The service was in receipt of an approved “Licence to Possess” controlled drugs, subject to the requirements of the Misuse of Drugs Act 1971; the certificate was valid until 20 April 2016 and was available for inspection at the time of our visit.
- There was a controlled drug signature sample list which was used to match signatures within the controlled drug registers against individual staff members.
- The manager was able to describe the process for reporting any adverse or untoward incidents which involved medicines or medical devices. This included the completion of a Sentinel incident report form as well as completing a Medicines and Healthcare Products Regulatory Agency (MHRA) “Yellow Card”. Additionally, the manager was able to describe how they responded to patient safety notices, alerts and other communications concerning patient safety incidents which required providers to act within a set timescale which were disseminated via the Department of Health Central Alerting System (CAS Alert).

## Medicines

- We saw that there were arrangements for the supply of medicines.
- We observed that medicines were kept securely and access to cupboards was controlled.
- Medicines that needed to be kept refrigerated were kept in dedicated medicines fridges between a temperature of 2 – 8oC. We found that the checking of refrigerator temperatures was sporadic with there being 12 occasions in May 2015 and 10 occasions in April 2015 when the refrigerator temperature was not recorded.
- There were systems for disposing of unused or partially used medicines in approved colour coded containers. These were kept securely and were collected by an accredited external contractor for destruction.
- We saw that medicines were administered by registered nurses following a doctor’s prescription; there were processes in place for ensuring that when a consultant cardiologist requested medication during an intervention and therefore provided a verbal order, two members of nursing staff confirmed the order with the consultant prior to the preparation and administration of the medication.
- We saw that prescription and administration records were fully completed and were retained in patients’ records. We checked five sets of patient records and found that the recording of medicines was complete including any drug allergies the patient may have had, legible details of the prescriber and those individuals responsible for administering drugs.
- A range of procedures required patients to receive sedation; there were protocols in place for this, with the preferred sedative Midazolam being used. A Central Alert was issued in 2008 which was associated with reducing the risk of overdosing patients with midazolam; the service was aware of this guidance and had a sedation protocol in place. Flumazenil is a drug which can be used to reverse the effects of drugs such as midazolam and is used when patients have been or are at risk of being over-sedated; there had been no reported incidents whereby flumazenil had been administered. Staff were aware of the risks associated with the use of medications such as midazolam and were aware of what action was required during emergency situations.

## Records

- Nursing and medical staff utilised procedure specific integrated care pathways. We reviewed four sets of patients notes during the inspection. We found that medical notes were well maintained. With the exception of patients who were attending the unit for angiograms, all other patients were required to attend a pre-assessment clinic prior to them attending for a procedure. Records demonstrated that the

# Diagnostic Imaging and Endoscopy Services

pre-assessment process included establishing patient's previous medical history, an overview of any medications they were currently taking, an overall health and wellbeing assessment to ensure they were fit for their proposed procedure and to provide patients an opportunity to ask any questions they may have regarding their procedure.

- Nursing staff were aware of the organisation's confidentiality policy and the manager was able to describe the responsibilities of the organisations Caldicott Guardian.
- Records were kept in line with the InHealth Ltd Healthcare Records Management policy.

## Safeguarding

- There had been no notifications regarding allegations of abuse from InHealth Ltd in 2014.
- 95% of staff had completed training with regards to the safeguarding of vulnerable adults. Staff were conversant with the local arrangements and policies that were in place for the escalation of, and management of vulnerable adults. Six members of staff could describe the various types of abuse and were able to sign post us to the organisations policy. Additionally, staff were focused on ensuring that patients continued to receive the necessary care and treatment whilst any safeguarding concern was being followed-up or investigated, as compared to pausing the delivery of care until such time as any investigation had been completed.
- 70% of staff had completed training in the safeguarding of vulnerable children. The manager informed us that the service rarely treated children, with two reported cases in 2014, however acknowledged that further work was required to improve the completion rate of the training.

## Mandatory training

- InHealth Ltd had a mandatory training programme. Completion of training was dependent on the role of each individual with some courses only needing to be completed by clinical staff.
- 100% of applicable staff had completed their mandatory training in fire safety and evacuation, moving and handling and basic life support.

- 90% of applicable staff had completed health and safety training, equality and diversity training and managing conflict training.

## Assessing and responding to patient risk

- We observed the catheter laboratory team utilise components and stages of the World Health Organisation (WHO) surgical safety checklist; this included a briefing by the lead cardiologist who set out each of the planned procedures for the list, as well as discussing and planning for any anticipated critical events. Additionally, staff undertook a process to both "Check in" and "Check out" patients at the beginning and end of their procedure.
- The provider acknowledged that the existing arrangements for the implementation and adherence to the WHO surgical safety checklist was such that it was not possible to effectively audit whether all members of the cardiology medical team and nursing staff utilised the various steps. The process for the completion of the safety checklist was being reviewed and was scheduled to be incorporated into the existing Integrated Care Pathway document although this had not taken place at the time of the inspection.
- The majority of patients undergoing planned procedures were invited to attend a pre-assessment clinic which could be facilitated either in person or via telephone. The pre-assessment process allowed for nursing staff to conduct pre-procedural blood tests and to carry out infectious diseases screening prior to the patients being admitted. Where patients tested positive for infections such as Methicillin Resistant Staphylococcus aureus (MRSA), there were procedures in place for ensuring that the patient was placed last on any surgical list and arrangements made for the laboratories to be deep cleaned on completion of the procedure.
- 95% of clinical staff had completed training in basic life support and four staff had completed training in advanced life support.
- Whilst the service did not utilise an early warning system to aid in the recognition of deteriorating patients, we checked four sets of patient notes and found that regular post-procedural observations (pulse rate, blood pressure, respiratory rate,

# Diagnostic Imaging and Endoscopy Services

temperature and pulse oximetry) were carried out; we observed staff escalating patients to the lead cardiologist when they were concerned about the clinical condition of the patient.

- In the event of emergency situations, staff could summon additional support from the hospital “Patient at risk” team who would respond within a short period of time.

## Nursing and allied health professional staffing

- The current establishment for the service was 6.8 wte nursing staff, 3.8 radiographers and 3.1 health care assistants. There were 1.8 wte vacancies for nursing staff, with some shifts being back filled with bank or agency staff. 27 shifts had been covered by bank staff and 8 by agency staff in the preceding three months leading up to the inspection. We reviewed rosters which demonstrated that the same nurses were used to cover the unit which assured the manager that only staff who were familiar with the unit and who had been assessed as competent were helping to support the unit.
- We reviewed records which demonstrated that bank and agency staff were inducted to the clinical area, underwent competency assessments to ensure they were suitable for the carrying out of the required nurse duties and for ensuring that their professional nursing registration was active with the Nursing and Midwifery Council. In addition, there was evidence of post-graduate training such as attendance at advanced life support course.
- 3 nurses and 1 radiographer had left the service in the previous year. Whilst the manager did not conduct formal exit interviews, they did meet with individual staff to ascertain their reasons for leaving; there were no patterns identified from the four staff who had left.
- In the preceding three months leading up to the inspection, the sickness rate amongst nurses was 10% and 5.5% for radiographers.
- There was an internal process for ensuring that all nursing and allied health care professionals were registered with their professional regulatory body; 100% of applicable staff had had their professional registration checked in the preceding twelve months.

- Whilst the service did not utilise a specific acuity tool, nursing levels were determined dependent on the type of diagnostic/interventional list that was scheduled to take place daily. The registered manager liaised with nursing staff to ensure that where staff shortages existed, staff were redeployed within the department to ensure that there were sufficient staff to meet the needs of patients.
- We reviewed a staff tracker for March – May 2015; the tracker demonstrated that nursing levels were only at full complement on 13 out of 90 days during that time period. Staff reported that whilst they were redeployed, the majority of them were competent to work across the unit and so enjoyed the variability the role offered. Some staff were happy to be allocated solely to one place of work such as within the admission and recovery area whilst others preferred to work in the cardiac laboratory but all grades of staff acknowledged the importance of rotating through the unit so as to maintain their various skills.
- Nursing and radiography staff supported an out of hour’s roster which enabled inpatients at the local hospital access to diagnostic and interventional cardiology services in the event of clinical emergencies.

## Medical staffing

- The service utilised the clinical expertise of ten consultant cardiologists who were employed by the commissioning trust and other NHS trusts. Consultants provided 24/7 support to the unit and operated an on-call rota in the event that a patient required interventional or diagnostic care out of hours. Consultants delivered the majority of diagnostic and interventional care whilst also being supported by a small number of senior trainee doctors.
- Each consultant was governed by local “Practising Privileges” rules. There was an assigned clinical lead who was responsible for ensuring that consultants practiced in line with their scope of competence. There was a central process for ensuring that those doctors working under practising privileges were suitably registered with the General Medical Council as well as having the necessary indemnity insurance. One consultant had been identified by the service as not having current evidence of revalidation or indemnity

# Diagnostic Imaging and Endoscopy Services

insurance on file and so there was a process for suspending the individual's privileges until such time that they could provide the necessary evidence and assurances.

## Major incident awareness and training

- The service had liaised with the commissioning trust to ensure that they were involved in the process of major incident management. Arrangements included having clear definitions of when beds located in the InHealth Ltd operated premises could be utilised by the Trust; this arrangement was instigated following a period of when the beds were routinely used by the neighbouring trust as an "Escalation" area.
- There were contingency plans in place in the event of incidents which were deemed to be a major incident including electrical power failure as an example.

## Are diagnostic imaging and endoscopy services effective? (for example, treatment is effective)

People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Clinical outcomes were monitored to ensure consistency of practice however further work was required to ensure that the quality and effectiveness of nursing outcomes were monitored and actions taken where improvements were required.

There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking, peer review and service accreditation. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff.

## Evidence-based care and treatment

- The service used a range of policies and procedures which were based on national guidelines and best practice guidance. Local policies and procedures made reference to guidance from the National Institute for Health and Care Excellence (NICE) including the use of technical appraisal guidance documents (TA324 Dual-chamber pacemakers for symptomatic bradycardia due to sick sinus syndrome without atrioventricular block as an example) and interventional procedural guidance documents also

(IPG516 – Implantation of a left ventricular assist device for destination therapy in people ineligible for heart transplantation as an example). There was a process which was overseen by the cardiology clinical governance committee for ensuring that any national guidance utilised by the service was reviewed in line with any amendments that may have been made nationally.

- The service did not participate in the Imaging Services Accreditation Scheme (ISAS).

## Pain relief

- There were procedures in place for ensuring that patients were prescribed and administered pain relief. We spoke with six patients who had all undergone diagnostic procedures; they reported that staff had spoken to them during the procedure to offer them reassurance, and where they had complained of pain, staff had responded by administering pain relief.
- The service was not actively auditing care records or patient experiences to determine whether pain was being effectively managed both during and post procedures so it was difficult for us to determine the overall performance of this criterion.

## Nutrition and hydration

- We saw that as part of post-procedural care patients were provided with drinks and a light meal prior to them being discharged home.
- As part of the pre-assessment process, patients were provided with advice regarding their requirements to be nil-by-mouth prior to their procedure. Information was also contained within the case specific integrated care pathways detailing nil-by-mouth requirements. Nursing staff reported that for patients who had been identified as being insulin dependent diabetics, patients could be admitted to the coronary care unit the evening before to ensure that appropriate pre-operative medical intervention and treatment could be provided including the use of "Sliding scale" insulin infusions.

## Patient outcomes

- Data from the British Cardiovascular Intervention Society (BCIS) Consultant Percutaneous Coronary Intervention (PCI) Operator reports dated 1 January



# Diagnostic Imaging and Endoscopy Services

2012 to 31 December 2013 demonstrated that there were no concerns with regards to the measured major adverse cardiac and cerebrovascular event (MACCE) rates per 100 procedures.

- The service participated in the Myocardial Ischaemia National Audit Project (MINAP); data set quality submitted for 2013-2014 was worse than the average of similar non-primary PCI capable centres nationally (70.6% of data submitted by the cardiac team was complete versus a national average of 87.8%). The service acknowledged that improvements were required in completing a range of datasets to enable the national audit team to effectively risk adjust audit outcomes.
- The number of patients waiting less than 72 hours for PCI in non-ST elevated myocardial infarction (a form of heart attack) was better than the national average according to data from the 2013 BCIS audit data (79% of patients waited less than 72 hours as compared to a national average of 55.1%).
- The MINAP 2013/2014 audit data demonstrated that the service performed better than the national average with regards to the median “Call to Balloon” time of less than 150 minutes (the call to balloon time is a measure from which a PCI service receives a call advising a patient has a form of heart attack which requires a catheter “Balloon” to be inserted into a heart vessel in order to dilate (open) a block vessel). Evidence shows that the shorter a patient is required to wait for a vessel to be “Ballooned”, the better the outcome is for the patient. National median time for similar services was 112 minutes from call to balloon; InHealth Ltd reported a median call to balloon median time of 82.5 minutes.
- The median time patients could expect to wait on arrival to the unit before “Ballooning” took place was 58.5 minutes versus a national average time of 40 minutes.
- No patients who underwent a PCI during 2013 required emergency cardiac surgery; this was better than the national average of 0.05%.
- The service reported no patients as suffering from a cerebrovascular aneurysm (CVA) during a PCI; this was better than the national average of 0.09%.

- Due to the nature of the service, readmission rates as a result of complications associated with a diagnostic or interventional procedure within the cardiac catheter laboratory were not routinely monitored. This was because patients would present either to the commissioning trusts acute coronary care unit or direct to the emergency department. It was therefore not possible for us to determine whether patients were readmitted or required follow-up care as a result of their diagnostic or interventional procedure within the cardiac catheter laboratory.

## Competent staff

- 100% of nursing and radiography staff had received an appraisal in the preceding twelve months.
- Staff spoke positively about the appraisal system. We reviewed two appraisals and noted that individual objectives were aligned to the operational requirements of the service.
- Revalidation for consultants was undertaken by their employing trust; there was a process in place for ensuring that revalidation documentation was shared with InHealth Limited as required by consultants individual practising privileges rules and procedures.

## Multidisciplinary working

- Because of the nature of the contractual tenure of the service which was provided by InHealth Ltd, the manager had developed close working relationships with the general manager of the cardiology division who was employed by Ashford and St Peter’s NHS Foundation Trust. The manager attended regular governance meetings with the trust’s cardiac team during which time operational matters were discussed.
- A trust employed cardiac consultant acted as the clinical lead for the service and it was apparent from our discussion with staff from both the trust and InHealth that the relationship amongst staff was strong which led to a cohesive and functional multi-disciplinary team.
- The provider hosted annual Radiation Protection Meetings at which Radiation Protection Supervisors and Radiation Protection Advisors were invited to attend. We noted that the named RPS for the Cardiac Unit had not attended either the 2013 or 2014 meeting however a deputy had attended in their stead and the

# Diagnostic Imaging and Endoscopy Services

named RPS was aware of the discussions that had been had and was able to demonstrate the changes that had taken place as a result of the multi-disciplinary meetings taking place.

## Access to information

- Results from diagnostic and interventional procedures were reported and dictated by the consultant cardiologist who was responsible for performing the procedure. Discharge summaries were sent to patient's general practitioners although the turn-around time for this was not routinely monitored.
- It was noted that in the annual Health Quality Audit which was conducted on 17 April 2015 that compact discs containing copies of patient scans were sent by way of 1st class post to patients; a process had since been introduced to ensure that such confidential information was sent via recorded delivery.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Prior to any specific procedure a comprehensive consent document was provided that made explicit the specific risk for the proposed procedure and potential complications. Patients were provided with this in advance of their procedure day so they had the opportunity to read the information and seek any further information assurances they required.
- Some staff raised concerns that patients who attended for angiograms were not routinely pre-assessed and so were often required to consent to procedures on the day of admission; staff reported that in some cases, patients were required to additionally consent to interventional procedures such as angioplasties on the same day and so were not afforded the same time to consider the procedure, its associated risks and benefits as other patients who were invited to attend pre-assessment clinics. Where patients were not offered pre-assessment clinic appointments, information such as the British Heart Foundation guidance on Coronary Angiography, InHealth's guidance on coronary angiography and sample consent forms which list the risks and benefits associated with their proposed procedure were provided to patients.
- The nature of the service meant that there was no requirement for patients to be deprived of their liberty;

staff however, were aware of the requirements of the Mental Capacity Act and the concept of informed consent. Further, because some patients were sedated during their procedure, staff were aware that patients may not have the necessary capacity to make informed decisions at that time; staff informed us that a team discussion would be had and also a discussion would be had with a named emergency contact for the patient if it was deemed that it was in the best interest of the patient to proceed with an unplanned interventional procedure. Two consultants that we spoke with told us they would liaise with colleagues if they could not determine the best treatment options for a patient, especially if the intended procedure was categorised as very high risk; during those instances, if it was appropriate, the consultants informed us that they would stop the procedure, stabilise the patient and reverse their sedation and then meet with the patient post-procedure in order that all treatment options could be discussed to allow the patient to make an informed decision.

- Patients were provided with a copy of their consent form to retain for their reference.
- On the day of their procedure patients met with the consultant responsible for performing their procedure. A discussion was held which included again discussing the procedure, its risks and intended benefits as well as providing patients with alternative treatment options if they existed. We looked at four sets of patient notes and saw that the consent forms were all fully completed.

## Are diagnostic imaging and endoscopy services caring?

There was positive feedback from patients and those close to them about their experience of care and treatment. Patients were treated with kindness and relationships with staff were positive. Patients were supported to make their own decisions and were supported to understand their care and treatment and staff provided emotional support to assist patients to cope with their treatment.

## Compassionate care

- Each elective day case patient was provided with a patient satisfaction questionnaire following their

# Diagnostic Imaging and Endoscopy Services

procedure. Feedback from questionnaires was compiled by the provider and then reviewed by the registered manager to determine any themes or concerns about the care patients received.

- We spoke with six patients who were all very complimentary about the staff and the care and attention they had been shown. The staff were described as friendly and helpful and we observed this during the inspection.
- We observed that patients were treated kindly and with respect.
- In the Q1 2015 Patient Satisfaction survey, 98% of patients reported that they were given sufficient privacy during their stay.
- In the Q1 2015 Patient Satisfaction survey, 95% of patients reported that they were greeted promptly and courteously.

## Understanding and involvement of patients and those close to them

- We observed that patients were provided with a comprehensive range of information, including patient information guides specific to the procedure which they were undergoing. Consent forms also contained a range of detailed information to aid patients understanding of their treatment, other alternative treatment options, likely outcomes and risks and benefits.
- Patients informed us that the pre-assessment nurses talked to them about what to expect, the various procedures involved and possible outcomes.
- There were some concerns raised by patients that consultants did not always return to speak to them following their procedure and so were required to wait for their discharge summary to be sent to them; we discussed this with the registered manager who informed us that she was aware of the issue and that it was isolated to a small number of clinicians. During our inspection we observed medical staff returning to the recovery area to explain the findings of the investigations to the patient.
- In the Q1 2015 Patient Satisfaction survey 95% of patients reported that they were given sufficient

information to explain the next steps of their procedure and 97% of patients reported that they were given enough time and attention during their admission.

## Emotional support

- Patients were allocated named nurses on their admission to the unit; we observed nursing staff provide patients with explanations of what they could expect during their admission as well as being able to offer reassurance and to answer any questions patients may have had.
- Staff told us they could access the chaplaincy and religious support services provided by the neighbouring trust should patients request this service.

## Are diagnostic imaging and endoscopy services responsive to people's needs? (for example, to feedback?)

Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the service. Further work was required to ensure that laboratory utilisation rates and "Did not attend" rates were reviewed to ensure the service was as responsive as it could be.

Signage to the unit was not as good as it could be which led to complaints from patients; the provider was working with the commissioning NHS trust in an attempt to resolve this issue alongside issues with short stay car parking.

## Service planning and delivery to meet the needs of local people

- Services were provided to patients by way of a 24/7 call out service. The cardiac catheter laboratories operated from 07:30 – 18:30 Monday to Friday. The on-call service was provided between the hours of 17:00 and 08:00 Monday to Friday and from 17:00 on Friday to 08:00 Monday AM.
- Following a review of regional primary percutaneous coronary intervention (pPCI) services, the local clinical commissioning group requested a change to local treatment pathways so that InHealth Ltd, in



# Diagnostic Imaging and Endoscopy Services

conjunction with Ashford and St Peters NHS Foundation Trust commenced provision of a 24/7 pPCI services on a 24/7 basis commencing in July 2015. This meant that patients would be transferred direct to the unit by the local ambulance service with the aim of treating patients in line with national guidance.

- Consultants informed us that whilst the service was more efficient than other services for which they were contracted to support, with regards to waiting lists, further efficiencies in laboratory utilisation could lead to more enhanced management of patient waiting lists, therefore reducing the length of time patients were required to wait before being offered an appointment for admission. Service efficiencies had also been identified following an internal review of the service which was carried out on 23 and 24 February 2015 at which time it was noted that laboratories could be empty for periods of up to 30 minutes between procedures to allow for staff to clean the laboratory and to prepare for the next case. Further, it was noted that there was variation in the number of procedures booked per consultant. It was recommended as part of the February 2015 review that audits were undertaken to determine areas which could be improved however these had not been undertaken at the time of the inspection.

## Meeting people's individual needs

- We noted that patients had raised concerns regarding the lack of waiting facilities for their relatives. During our inspection, relatives were required to wait in a small waiting area located outside the unit. A report from the provider stated that "Due to regulation of not permitting gender mixing, and due to space restrictions in the unit, it is not possible to allow relatives/spouses to remain with the patient. The relative can stay until the patient is prepared for their procedure and there is flexibility of seeing the patient at interim periods." Guidance from NHS England states that "Visitors cannot breach the mixed sex accommodation standard as they are not admitted patients".
- Some patients had also raised concerns that it was difficult to locate a convenient parking space to use when collecting patients who had been discharged. Whilst car parking on the campus was managed by the commissioning NHS Trust, the registered manager had

entered into discussions with the trust in an attempt to secure a parking space directly outside the unit. Reception staff advised patients and relatives that they could park directly outside the unit so long as they were not intending to stay for prolonged periods of time. Additionally, patient information was provided which sign posted patients to the nearest car park although we found that during the inspection, signposting for this car park was poor.

- As part of the pre-assessment process, patients living with dementia or those living with learning disabilities were identified and additional resource allocated on the day of their admission to support them through their planned procedure. Where patients were assessed as not being appropriate to undergo a procedure with the use of conscious sedation, there was a process in place for the patient to undergo a general anaesthetic on a planned list. It had been recognised that staff required additional training and support from the Admiral nurse with regards to receiving additional training on managing patients living with dementia and that there was an action plan in place for this individual to delivery face-to-face training by September 2015. As an interim measure, nursing staff told us that they could liaise with the NHS Trust's Admiral Nurse who was a specialist dementia nurse and who was available to provide support to families, patients and staff.
- Following the services' annual health quality audit, it had been identified that the reception desk had been installed with a hearing loop device although staff were not aware of how to use it. The manager had recognised the need for staff to undergo training in order that the system could be effectively utilised.
- In order to reduce the occurrence of mixed sex breaches, the day case area had been separated in to two areas, each containing five beds. Procedural lists were developed to ensure that there were sufficient numbers of beds available on each side of the day case recovery area. A review of Sentinel reports indicated that no mixed sex breaches had occurred.
- The service had access to interpreter services in order that they could meet the needs of the varied population. We found that on the day of the inspection an interpreter had been arranged for a patient whose first language was not English.

# Diagnostic Imaging and Endoscopy Services

- Although the service did not have a dedicated mortuary for which they were responsible, there were arrangements in place for transferring deceased patients to the mortuary located on the campus of St Peter's hospital. There were local policies and procedures available to support staff and relatives with regards to managing deceased patients.

## Access and flow

- At the time of the inspection, 62 patients were on a waiting list and awaiting an admission date; 25 of those patients had been waiting for more than six weeks and 5 patients had been waiting for more than 13 weeks. The provider was responsible for reporting on a monthly basis to the contracting trust all patients who were waiting longer than 6 weeks for diagnostic procedures and those on a therapeutic international normalised ratio waiting list of more than 18 weeks. Clinicians had oversight of waiting lists to ensure that those patients waiting longer than intended had been risk assessed so as to ensure that it was appropriate for them to wait for allocation of an admission date.
- The provider reported that in April 2015 the "Did not attend" rate was 16.5%. Between January and December 2014 there were 278 occasions when patients did not attend for their planned procedure. There was a process in place for ensuring that patients who did not attend their appointment were contacted and another appointment offered to them; a copy of the referral letter was sent to the consultant cardiologist assigned to oversee the patient's care advising that the patient had not attended and an alternative date had been provided to the patient. Where patients failed to attend for their second planned appointment date, the patient was removed from the waiting list and a letter sent to their General Practitioner informing them of the two repeated non attendances.
- A review of patient comments received as a result of the patient satisfaction survey revealed that some patients had experienced delays from when they arrived for their procedure to when they were actually sent to the catheter laboratory. We were told that all patients scheduled to attend for a morning list were asked to arrive between 07:30 and 08:00. The consultant cardiologist would determine the order in which patients would be called for to attend the

catheter laboratory. When the running order of lists was known, nursing staff would inform patients so they were aware of the approximate waiting time. Six members of staff informed us however that one consultant was known to amend the running list of the morning list which meant it was not always possible to provide approximate waiting times to patients which resulted in some patients becoming anxious as a result of prolonged waits. Data from the Q1 2015 patient satisfaction survey reported that 11% of patients considered they were kept informed on the day, 11% considered they were not kept informed and 78% did not answer the question.

- In the Q4 2014 Patient Satisfaction survey, 97% of patients said that appointment waits met their expectations; 1% reported that they would have preferred a longer appointment time.

## Learning from complaints and concerns

- Nursing staff were able to describe how they dealt with complaints. This included listening to the patient, respecting what they said, making a note of the matter and explaining how it would be dealt with. Generally staff said they would pass information to the registered manager or most senior member of nursing staff for action.
- The provider reported that two complaints had been received by the trust and, on further investigation had involved components of care which had been provided within the cardiac catheter laboratory which was hosted by InHealth Ltd. Joint investigations took place for each complaint with joint responses sent to each complainant from the Chief Executive of Ashford and St Peters NHS Foundation Trust. There was evidence that amendments to the service had taken place following the complaints including reviewing the information provided to patients with regards to what they could expect to happen on the day of their procedure as well as a revision of the environment so that a small waiting area could be created for relatives
- Patients told us they had not felt the need to raise a complaint but if they did, some were aware of the process and others said they would find out. We observed information which advertised details of how patients could provide feedback and to raise concerns about the service or care they had received.

# Diagnostic Imaging and Endoscopy Services

## Are diagnostic imaging and endoscopy services well-led?

The organisations vision and values were not fully embedded within the service; there was confusion amongst staff with regards to the “Inhealth way” accreditation system,

The arrangements for governance and performance management did not always operate effectively; risk registers were not always effectively used so it was not possible to determine what oversight specific risks had nor was there evidence of how some risks were being effectively managed. Staff raised concerns with the proposed introduction of a formal 24/7 primary percutaneous coronary intervention service as there was insufficient nursing and radiology staff to support the service. This had been identified by the provider as part of the initial business case and recruitment was continuing although it was unclear how the provider was intending to robustly mitigate the risk to patients upon the introduction of the service.

The local leadership was seen to be approachable and there was a “Can do” attitude where staff went “The extra mile”. Relationships between the provider and the main commissioning NHS trust was good and there was engagement with professionals from both organisations with regards to the oversight of risks.

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

- Some nursing and radiography staff that we spoke with were aware of the Provider’s wider “InHealth Way” vision and strategy however considered that the strategy was not fully embedded at a local level. The Inhealth way framework had been devised to help services to evolve in order to meet the needs of the local population and was underpinned by a range of fundamental and regulatory frameworks to enhance the quality of services. Services were assessed and rated through levels 1, 2 and 3. At the time of the inspection the service had been rated as attaining level 2; there was some confusion amongst staff on what was required of them to attain a level 3 accreditation.

## Governance, risk management and quality measurement for this core service

- The service utilised a clinical, general and local risk register which was provided to us prior to the inspection. The register contained a range of risk assessments which encompassed risks ranging from electrical mains failure to the storage of medical gas cylinders.
- The top 6 risks for the service included mains electrical failure whilst undertaking procedures in the cardiac catheter laboratory, the safe disposal of sharps, use of syringe drivers, managing aggressive or agitated patients in response to the administration of conscious sedation medication, insertion and removal of indwelling devices and use of ionising radiation. A range of risk assessments complimented the risk register in order to assist in reducing the overall impact of harm associated with each risk.
- However, it was noted that issues such as foreseeable staffing issues had not been transcribed to the risk register although it was acknowledged that the provider had ascertained that a potential risk existed within the initial business case that was associated with the expansion of the pPCI service. Additionally, the issue of staff members utilising two different incident reporting systems had not been identified as a risk and there was no clear plan for resolving the issue.
- A range of staff raised concerns with us that the introduction of a primary PCI service which was scheduled to commence in July 2015 would place additional pressure on the service as a result of a requirement for nursing and radiography staff to attend more frequent out-of-hour call outs. A review of the business case associated with the introduction of a 24/7 pPCI service listed nursing and radiographer resource as a risk; in order for the service to effectively support a 24/7 service, a total of 13 WTE competent nursing staff were required. At the time of the “Go-live” only 8 WTE nurses were deemed to be competent to support the on-call rota. In addition, the 24/7 service required 5 WTE radiographers; at the time of the proposed “Go-live”, only 3 WTE radiographers were available to support the on-call rota. Whilst the frequency of call-outs as a result of the introduction of the new 24/7 service was expected to be

# Diagnostic Imaging and Endoscopy Services

approximately 2 call outs per week, staff were concerned that there was limited nursing and radiographer support to ensure that elective day lists would be supported in the event that they were called out during the preceding night. We noted that the service had created a “People plan” which had been generated following staff consultations. Every member of staff that we spoke with raised concerns about the suitability of the roster as it required staff to undertake additional on-call duties; staff acknowledged that additional resource had been recruited but considered that the introduction of the 24/7 service should be delayed until all members of the workforce were inducted and had been deemed competent in order that there was sufficient resource to support the on-call rota. Following the inspection, we requested supplementary information from the Provider to determine whether they have commenced with the 24 hour pPCI service; the provider confirmed that this had commenced on 1 July 2015). The provider reported that there had been no reported staffing issues nor had there been any cancellations of elective lists as a result of the introduction of the service. Additionally, the service was utilising bank and agency staff who were familiar with the unit and who were trained in the provision of coronary care to support the service. There was a process for ensuring that all new cases referred for pPCI were audited and reviewed weekly to ensure that referrals met with agreed standards.

- The manager attended routine clinical governance meetings; we reviewed minutes from meetings which demonstrated that incidents, morbidity and mortality reviews, clinical guidelines and operational matters were discussed with a range of individuals including operational managers and clinicians.
- Whilst the provider had a range of systems in place to ensure that locations were complying with corporate policies including the Health Quality Audit and Rapid Benefit Analysis reviews, there was very limited evidence of robust audit programmes to demonstrate how the provider was measuring their overall clinical effectiveness, especially with regards to nursing quality and outcomes. Further, from our discussions with the senior management team, there was no

evidence that the service was undertaking audits, as has been recommended following internal reviews, into areas such as laboratory utilisation, consultant list allocations (procedural outliers) and laboratory turnaround times.

- The provider was certified with ISO 9001; assessment of this standard had included a site visit by the assessing officer to the InHealth Ltd Cardiac Unit at St Peter’s Hospital on 13 March 2014.
- A contractual requirement was for the service to obtain monthly patient feedback from 15% of patients (10% elective day case and 5% in-patient feedback). Data from the Q4 2014 patient satisfaction dashboard reported that feedback was received from 10.4% of patients (113 patients). Data from Q1 2015 demonstrated that feedback had been received from 18.7% of patients during that quarter.

## **Leadership/culture of service for this core service**

- Staff told us that the local leadership was very strong and individuals were very visible and that they received support and guidance from the leadership team. We noted that there was a strong professional relationship between the local management team and the clinical lead. Although employed by the NHS trust, the clinical lead considered that the team provided by InHealth Ltd was an integral part of the cardiac service at St Peter’s Hospital and that this was as a result of the clear leadership, professionalism of all nursing, radiology and support staff and the general sense of “Going the extra mile” for patients.
- The service had conducted a local staff survey during February and March 2015 from which findings were identified and reported back to staff during a team meeting in April 2015. One theme included a “Disconnect between the senior executive team and the unit regarding the day to day running of the unit”. Actions from this theme included the senior clinical lead feeding back these findings to the senior executive team. During the inspection, staff told us that they acknowledged the difficulty the executive team had with regards to attending the site and that this was attributed to the size of the organisation and the number of locations the provider operated from.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider **MUST** take to improve

1. Review the existing governance arrangements to ensure that staff report incidents in a standardised way, utilising the provider's standard incident reporting system.
2. Review the existing risk management strategies to ensure that risks relevant to the service are recorded on the local risk register and escalated to the senior executive team in line with internal policies and procedures.

### Action the provider **SHOULD** take to improve

- The provider should consider reviewing its existing audit programme to ensure that where recommendations are made, action is taken to address areas which could lead to improvements in the quality of care that is delivered to patients.
- The provider should consider reviewing the staffing establishment prior to the commencement of the pPCI service to ensure that there are sufficient numbers of nursing and radiography staff with the relevant skills and competence to support the proposed on-call rota whilst also sustaining the elective day-case workload.
- The provider should consider reviewing the environment to ensure that relatives can be present to support those patients who are anxious or nervous prior to and after their procedure.
- The provider should consider reviewing the existing parking arrangements so that patients who have undergone diagnostic or interventional procedures can be collected more easily.
- The provider should consider reviewing the signage to the cardiac unit so that it is easier for patients and visitors to find the unit.

## 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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance</b></p> <p>There was an inconsistent approach to how staff reported incidents; there was a high threshold for reporting amongst staff and staff were not routinely following local policies and procedures. This impacted on the ability of the provider to be assured that the assessment, monitoring and mitigation of risks was sufficiently robust.</p> <p>Whilst the management team were aware of specific risks which had the potential to likely impact on the clinical effectiveness of the service, these risks had not been formally recorded or assessed and as such there was a lack of assurance with regards to how risks were likely to be mitigated.</p>