The Cardiac Catheter Laboratory

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Cardiac Catheter Laboratory is operated by InHealth . The service provides a one purpose built Cardiac Catheterisation Laboratory. Facilities include one scanner control room, one scanning laboratory room and a six-bedded day ward.

The service provides a range of cardiac procedure services for adults. We inspected the service under our independent single speciality diagnostics imaging framework, using our comprehensive inspection methodology. We carried out a short notice announced inspection on 9 April 2019.

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

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

We found good practice in relation to diagnostics imaging:

- The service managed patient safety incidents well. Staff knew what constituted an incident and could demonstrate how to use the electronic reporting system.
- The service provided mandatory training in key skills to all staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service-controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Staff kept detailed records of patients' care and treatment. Records were clear and up-to-date.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service followed best practice when prescribing, giving, recording and storing medicines.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Overall summary

The Cardiac Catheter Laboratory is operated by InHealth . The service opened in February 2013. The Unit is operational on Tuesday and Thursday 7.30 am until 6pm, and Friday mornings 7:30 am until 2:30pm.

Pre-assessment clinics were running on Wednesdays 8:30 am to 5pm.

The Cardiac Catheter Laboratory is based at the host hospital, in Burton upon Trent and provides a cardiac diagnostic and therapeutic imaging service to the local population of Burton upon Trent, Tamworth, Lichfield, Derby and surrounding areas.

The service has had a registered manager in post since February 2013.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	**The service provides a range of cardiac procedure services for adults and was the only activity this service provided.** **We rated this service as good because it provided a safe, caring, responsive and well led service. We do not rate effective.**

Summary of findings

Contents

Good

Services we looked at was Diagnostics Imaging

Summary of this inspection

Background to The Cardiac Catheter Laboratory

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Our inspection team

The team that inspected the service comprised a CQC lead inspector, and a specialist advisor with expertise in diagnostics imaging. The inspection team were overseen by Victoria Watkins, Head of Hospital Inspection.

Information about The Cardiac Catheter Laboratory

The Cardiac Catheterisation Laboratory is a purpose-built unit with one direct access entry point at street level. The Unit is adjacent to the host hospital Coronary Care Unit and a Medical Ward, which can be accessed by a door which remains open in-hours and locked out of hours with access via a key card.

The Unit encompasses a waiting area for patients and their family/friends, one Cardiac Catheterisation Laboratory equipped with imaging equipment and a six-bedded day ward divided into two sections with separate entrances to allow for single sex accommodation.

There are separate toilet facilities for male and female which both have disabled access. The Unit also has a changing room with toilet and locker facilities for staff, along with a very small kitchen providing hot and cold water, along with refrigeration and storage for staff food.

The premises are managed by the host hospital; however, all equipment belongs to InHealth

During the inspection, we visited the day ward, the laboratory room, control room, bathrooms, staff changing room, and waiting area. We spoke with seven staff including registered nurses, health care assistants, medical staff, radiographers, physiologist and senior managers. We spoke with four patients and one relative. During our inspection, we reviewed six sets of patient records.

We did not carry out any special reviews, and there were no investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once before but was not rated, since the new CQC methodology this is the first time this service has been rated.

Activity (October 2017 to September 2018)

- The service treated over 1,005 patients during the year.

The service employed one angiography services manager, one senior cardiac nurse, three cardiac nurses, one cardiac physiologist, one health care assistant, one cardiac radiographer. The accountable officer for controlled drugs (CDs) were the registered manager.

The service reported:

- Zero Never events
- No serious injuries

Summary of this inspection

- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired Escherichia Coli (E-Coli)
- No complaints currently open

Services accredited by a national body:

- InHealth aim to be accredited across diagnostic and imaging services by 2020 with the Imaging Services Accreditation Scheme (ISAS) and are using the traffic light ready tool and gap analysis to prepare for inspection.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Pharmacy support
- Use of hospital facilities
- Interpreting services
- Grounds Maintenance
- Laundry
- Maintenance of premises
- Pathology and histology
- Catering for patients
- Infection prevention & control

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

- Staff recognised incidents and reported them when needed. Managers investigated incidents and shared lessons learned with the team and the wider service.
- The service mandatory training compliance rate was met for all staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. All staff had received the required level of safeguarding training.
- The service-controlled infection risks within the department. Staff kept equipment and premises visibly clean. The service used appropriate control measures to prevent the spread of infections
- The service employed staff with the right qualifications and skills to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Patient records were clear and up to date, that included all key information, staff kept up to date records of patients' care and treatment.
- The service had suitable premises and equipment, and these were well maintained, there was adequate availability of emergency and specialist equipment for patients.
- The service had systems in place to recognise and respond to deteriorating patients' needs and clinical risks.
- The service prescribed and stored medicines in line with local and national guidelines. Documentation around medicines was consistent, documents and temperatures for the storage of medicines was recorded appropriately.

Are services effective?

- The service provided care and treatment based on national guidance. Local and national audits as such were completed, and actions were taken to improve care and treatment when indicated.
- Staff met patients' nutrition and hydration needs.
- Staff had the skills, knowledge, and experience to deliver safe care and treatment. Staff were appraised annually.
- Staff assessed and managed pain on an individual basis and regularly monitored throughout patient care.

Summary of this inspection

- The multidisciplinary team worked well together to support patients holistically; consultants, radiographers, physiologist, nurses and other healthcare professionals supported one another to provide good care.
- Health promotion materials were available throughout the unit and staff knew which services to signpost patients to.
- Consent was taken on the day of procedure by the cardiologist consultant on the day ward and then checked again in the cardiac catheter laboratory.

Are services caring?

Good

- Staff cared for patients with compassion and respect. Patients feedback and those close to them throughout our inspection was positive.
- Staff treated patients with dignity, respect and empathy.
- Patients' emotional and social needs were considered as important as their physical wellbeing.
- Patients who used the service and those close to them were active in their care and treatment.

Are services responsive?

Good

- Patients' needs, and their preferences were considered and acted upon to ensure services were delivered and accessible in timely manner. The service planned and delivered services to meet the needs of people using the service.
- Staff had access to interpreters to aid communication with their patients. Patient's needs were considered when delivering and coordinating services, including those who were vulnerable and had complex needs.
- Access to care was managed to take account of patients with high risk needs. Patients had access to the right care at the right time.
- Patients concerns, and complaints were investigated, lessons were learned from complaints, shared with all staff and all complaints were dealt with in a timely manner.
- The service kept patients and relatives informed when there were delays.

Are services well-led?

Good

- The vision and values were aligned to both InHealth and the host hospital.
- The service had a supportive, competent manager who promoted a positive learning culture.

Summary of this inspection

- The governance arrangements within the service, were clear and operated effectively and staff understood their roles and accountabilities.
- The service had a system in place for identifying risks, planning to eliminate and reduce risks and the ability to cope with expected and unexpected challenges within the service, managers had an oversight of the service.
- The service had a vision of what it wanted to achieve and plans to turn it to action.
- Management collected, analysed, managed, and used information to support the service activities using secure systems with security to safeguard all processes in use.
- Staff engaged well with patients, staff, and the public and local organisations to plan and manage appropriate services and collaborated with host hospital effectively.
- The unit was committed in improving services by learning from things that have gone well and when things go wrong, promoting training, research, and innovation.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

We rated safe as good because:

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
  - The service followed the provider's corporate mandatory training policy. Staff were required to undertake a wide range of general and role specific mandatory training modules in line with their policy and training schedule.
  - Training and development included 'face to face' and 'e-learning' modules. Staff training was kept up to date and each staff member had their own logging system to manage their training online. The service manager also kept their own training record and sent reminders to let staff know when their training was due.
  - All staff completed their mandatory training (100%), which exceeded the service's target of 90%. All staff working with radiation had appropriate training around regulations, radiation risks, and use of radiation.
  - The unit had the "area local rules for radiation safety summary" on display which had been reviewed in March 2019. The unit also had a nominated Radiation Protections Supervisor and found letters of appointment was in date under the Ionising Radiation Regulation 17 (IRR17).
  - Training modules included fire safety and evacuation, equality and diversity, health and safety, infection prevention and control, safeguarding level one and two both children and adults, customer care, moving and handling, information governance (IG), basic life support (BLS) and Immediate Life Support (ILS).
  - All clinical staff were either trained in ILS or BLS, we saw evidence that all staff were required to complete a set of mandatory training courses during their first three months of employment with the service.
  - Staff told us they could access mandatory training when they required it.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The service did not treat children.**
  - Staff were aware of their role and responsibilities in making safeguarding referrals. Staff showed us their clear safeguarding guidance on the host hospital intranet and their own service policy and told us this was easy to follow.
  - Staff we spoke with demonstrated a good understanding of safeguarding and knew who to contact within the safeguarding team based at the host hospital.
  - Safeguarding vulnerable adults and children level two training was included in the services mandatory training programme, and 100% of staff had completed their safeguarding training.
  - Staff told us, when a safeguarding concern was identified, the initial trigger was raised within InHealth,

including the line manager and the designated person for safeguarding at the host hospital. Any investigations carried out were shared between the host hospital and InHealth.

- Senior managers told us that all patients referred to the cardiac catheterisation laboratory belong to the host hospital trust, and in line with the host hospital trust safeguarding policy, InHealth would raise all safeguarding concerns with the host hospital named person for safeguarding referrals. InHealth were also responsible for raising concerns to their own clinical governance team in line with the InHealth adult and children's safeguarding policy.
- We saw the reporting pathway was on display in the laboratory control room as a reference for staff.
- Staff told us, and we saw that the service discussed safeguarding concerns during their weekly Complaints, Litigation, Incident, and Compliments (CLIC) meetings along with a biannual safeguarding board that monitored compliance with safeguarding policies, raising concerns processes and the ability to identify themes.
- The unit had a system in place for recording and reporting Female Genital Mutilation (FGM). FGM, also known as female genital cutting and female circumcision, is the ritual of cutting or removal of some or all the external female genitalia. Staff followed the host hospital guidance for FGM and to safeguard their patients. The guidelines discussed the FGM mandatory reporting processes and caring for women who had undergone FGM.

Cleanliness, infection control and hygiene

- **The service-controlled infection risks within the department. Staff kept equipment and premises visibly clean. They used appropriate control measures to prevent the spread of infections.**
- Cleanliness, infection control and prevention and hygiene were monitored through a process of internal and external audits. As the unit was an extension of cardiology services provided by the host organisation, InHealth services adhered to the host hospital's infection prevention and control policy and protocols. As such, an InHealth infection control link nurse provided support to the local team to ensure compliance.
- Information relating to the management of patients with a communicable disease was embedded within InHealth service infection prevention and control policy. A communicable disease is one that can easily spread from one person to another through a variety of ways that include: contact with blood and bodily fluids; breathing in an airborne virus; or by being bitten by an insect.
- Staff we spoke with told us that patients who had been identified with any infection control risks were allocated an appointment at the end of the day. This meant risks of cross infection to other patients was reduced and the area could be deep cleaned afterwards with the appropriate cleaning materials.
- During the pre-assessment appointment all patients due to be admitted for procedure were swabbed for potential infections such as Methicillin-resistant Staphylococcus aureus (MRSA). MRSA refers to a group of gram-positive bacteria that are genetically distinct from other strains of Staphylococcus aureus. MRSA is responsible for several difficult-to-treat infections in humans. Patients were only admitted for procedure if no infection was identified.
- Information provided by InHealth identified that from December 2017 to December 2019 there had been no cases of MRSA, C. difficile, E. coli or MSSA infections.
- The unit was visibly clean, tidy and clutter free. The ward area, control room and scanning areas had an environmental cleaning schedule. We saw completed cleaning schedules for daily cleaning and deep cleaning including sterile and decontamination regime, all schedules we reviewed were signed and dated.
- The service's annual infection prevention and control audits identified no concerns with the management of infectious patients.
- All clinical areas had soap dispensers and paper towels, areas had antibacterial rub dispensers, which were allocated throughout the department.
- Infection prevention and control measures were in place to ensure patients were protected against healthcare-acquired infections whilst in the

department. Staff received infection control training as part of their mandatory training. Between September 2017 and December 2018, 100% of staff were compliant with hand hygiene audit.

- There were dispensers for aprons and gloves, and we observed staff wearing gloves and aprons when carrying out treatment. These were disposed of in clinical or non-clinical waste bins as appropriate.
- We observed staff complied with infection prevention and control practices, staff appropriately washed their hands between direct contact and care with patients, all staff were bare below the elbow.

Environment and equipment

- **The service had suitable premises and equipment, and these were well maintained. There was adequate availability of emergency and specialist equipment for patients.**
  - We saw 'Welcome' poster in the waiting area, with staff pictures for members of the public to see who oversaw the department.
  - Responsibilities for equipment premises safety and maintenance was shared between the host hospital and InHealth services we saw safety and maintenance checklist on display.
  - Daily equipment checks were undertaken to ensure equipment was in good working order. Staff we spoke with were aware of the process for escalating faults with equipment, routine servicing and manufactures.
  - There were systems in place for patients who suddenly felt unwell during their procedure. All staff were aware of the process and we saw that resuscitation equipment was readily available. Resuscitation equipment was checked daily and all equipment was tested and in date.
  - Risk assessments were in place and reviewed quarterly for the use of ionising radiation, safety equipment was provided to all staff for protection against exposure to radiation.
  - Warning signs highlighting hazards throughout the unit were on display where necessary. Posters were on display in the control room with details of how to keep radiation doses to a minimum for staff and patients during interventional cardiology.
  - All sharp instruments such as, syringes and clinical and offensive waste were discarded in the appropriate containers and stored in locked cupboards located away from the clinical areas. These were secured by keypads or card passed by which they were not accessible to anyone without an appropriate pass.
  - All staff undertook fire safety training. All fire exits were clearly marked, and fire alarms were regularly checked. Evacuation plans were clearly displayed and included evacuation routes.
  - We reviewed the unit's environment and equipment cleaning audits for February 2019 and found all areas were 100% compliant against their target of 90%.

Assessing and responding to patient risk

- **The service had systems in place to recognise and respond to deteriorating patients' needs and clinical risks. Observations of the patients were recorded using the National Early Warning Score (NEWS) system, staff demonstrated good understanding of how and when to escalate if a patient was to deteriorate.**
  - During our inspection, we saw patient's safety risks were reviewed throughout each patients' pathway. At the pre-assessment clinic, nurses told us they followed guidelines to ensure appropriate information regarding each patients' suitability for their procedure, this captured patients' health risks prior to any clinical intervention this also included pregnancy, all women were asked if they were pregnant prior to any treatment during their pre-assessment appointment.
  - We observed staff providing advice to patients on medicine for their blood and those with a reduced renal function, we also saw all relevant advice was documented in patient's integrated care pathway documentation.
  - Staff undertook safety checks prior, during and after each procedure. All safety checks were clearly documented in patient records.
  - Staff followed the National Early Warning Score (NEWS) to assess patients' clinical conditions and identify medical deterioration. National early warning system was used for identifying the acutely ill patients.

Diagnostic imaging

- InHealth provided all staff with radiation protection training, which was provided by an InHealth radiation protection advisor and team of radiation protection supervisors at location level. All staff we spoke with were aware of the protocols.
- Risk assessments were carried out for risks such as fire hazards, trip hazards, equipment and electrical safety checks. Managers told us that any health and safety risks were reported and highlighted on regular basis. The health and safety processes were reviewed annually to ensure that risks were minimised when caring for patients.
- We observed staff wearing lead aprons and thyroid shielding equipment to mitigate risks relating to radiation exposure.
- The Society and College of Radiographers, "have you paused and checked?" posters were on display in the control room, to remind staff to follow correct processes. The "have you paused and checked?" process was undertaken to ensure the right person had completed all safety checks. We observed this practice whilst on inspection.
- We reviewed the unit's emergency and escalation policy and staff were able to demonstrate what actions they would take if a patient was to deteriorate. There was a formal agreement in place for patients to be transferred to the local NHS hospital if they required high dependency or critical care (level three). The service level agreement provided us assurance.
- The resident medical officer (RMO) provided the first response in an emergency. Staff told us that the RMO would review the patient quickly.
- Radiographers had access to the radiation protection advisor including a radiation waste advisor and radiation named supervisor by email, telephone or face to face if necessary for advice in relation to radiation.
- Emergency pull cords and nurses call bells were available in clinical areas and toilets.
- Radiographers, physiologists and consultants conducted a comprehensive checklist once the patient was in the treatment room. We observed, and staff told us that the World Health Organisation (WHO) surgical safety checklist was adhered to. This is a process recommended by the National Patient Safety Agency to be used for every patient undergoing a surgical procedure. The process involves several safety checks before, during and after surgery to avoid errors.
- We reviewed the 'WHO' documentation during this inspection and found all records were completed electronically. When we requested the 'WHO' checklist audit this was not yet completed, the service manager told us that this was due to start April 2019 this was due to finalisation of the audit document.
- The service had systems in place to monitor the safety of staff working in a department with Ionising Radiation Regulations 2017 (IRR17), local rules for the procedure of all equipment were in place. A designated officer and radiation protection supervisors were responsible for carrying out checks on exposure to radiation, where applicable.
- The service reported zero Ionising Radiation Medical Exposure Regulations (IR(ME)R) reportable incident in the last reporting period of October 2018 to March 2019.

Nurses, Radiographers and other Staffing

- **The service employed clinical staff with the right qualifications and skills to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**
- The staff to patient ratio at the unit during the procedure was four clinicians to one patient (a consultant cardiologist, a cardiac radiographer, a registered nurse and a cardiac physiologist). There were no vacancy at present on the unit.
- Senior staff told us that agency staff were used on ad-hoc basis when bank or other internal resources could not be sourced. Agency staff were selected from a preferred supplier list and were known to the service.
- The management team told us, agency staff used were regular staff who were competent in supporting the requirements of the unit. The unit also had nurses from the host hospital coronary care unit who worked for InHealth on a bank basis, five trust nurses had completed the InHealth induction process and competency sign-off process for the day ward only.

Diagnostic imaging

- Each clinical member of staff had a designated role during procedures. In the event of a cardiac arrest, staff from the day ward would assist.
- We observed the unit 'huddle' that was held every morning, confirmation of the roles was provided to the team to ensure the appropriate level of support was available, this was also on display in the control room.
- The day ward had two three bedded bays adjacent to the nurses' station. Staffing consisted of two registered nurses and two Health care assistant (HCA). On the day of our inspection, patient ratio was one nurse to three patients in one bay, with another nurse looking after three patients with an HCA in another bay.
- Senior staff told us they did not use an acuity tool for the rostering of staff, due to the fixed nature of the service. However, staff rotas were available months in advance. Nurses rotated throughout the unit. During annual leave or unforeseen shortages, the service manager told us they would re-assess staff rotas and contact InHealth bank staff in line with the unit's business continuity plan.
- Staff we spoke with told us they could access 24-hour operational manager support. This was also supported by regional management and central support functions from InHealth to ensure the unit was appropriately staffed.
- Consultant cardiologist we spoke with told us advice and support were available internally from other consultant cardiologists based at the host hospital and other tertiary centres.

Records

- **Records were clear and up to date, and included key information, staff always keep up to date records of patients' care and treatment.**
  - There was an electronic patient record system in place at the unit. Referrals from other trusts and consultants were received through fax, email, and letters. Once received, referrals were scanned into the electronic patient record, this ensured all information were readily available.
  - NHS medical records were available for patients whose treatment was funded by the NHS.
  - Staff told us that patient notes were requested from medical records at the time of pre-assessment. Patient records were held on the unit on the day of the patient's procedure and stored in a locked cabinet based at the nurse's station.
  - During the procedure, nurses used the integrated care pathway (ICP) documentation, which was subsequently used during hand-over from procedure room to the ward until patients were discharged.
  - We looked at six sets of patient records and saw that all patient information and risk assessments had been fully completed.
  - The radiology information, images and communication used were secure, and could only be accessed using a password. Each radiographer had their own unique password.

Medicines

- **The service prescribed and stored medicines in line with local and national guidelines. Documentation around medicine was consistent, documents and temperatures for the storage of medicines was recorded appropriately.**
  - There were appropriate arrangements in place to store and administer controlled drugs. Controlled drugs are medicines that need extra checks and special storage arrangements because of their potential for misuse. Stock levels were appropriately limited and monitored regularly.
  - The host hospital pharmacy team supplied controlled drugs and stocked medicines, this was agreed following the service operating procedure (SOP) for controlled drugs, arrangements were also in place with the host hospital for disposal of all waste.
  - Staff had access to emergency medicines, these were stored appropriately on the emergency trolley. The medicines and log book were in date and correctly completed.
  - All medicine fridge temperatures including room temperatures we reviewed were within range and documented and actions were taken if outside their guidelines.
  - Patient allergies were clearly documented in their integrated care pathway and found to be accurately documented. Patients were advised to take their own

medication prior to procedure if this was safe to do so as per consultant instructions. Patients were required to bring their own medication with them to the hospital, and sign to say they were responsible for their own medicine and administration.

- We reviewed the units Medicines Management Committee (MMC) meeting minutes from the meetings held in September 2018 and January 2019. The meetings discussed all InHealth services across different regions, we found the meeting minutes to be robust and informative.
- We reviewed the contrast material used for catheter angiography (which is a thin plastic tube, called a catheter, inserted into an artery through a small incision in the skin. Once the catheter is guided to the area being examined, a contrast material is injected through the tube and images are captured using a small dose of ionizing radiation) and found it was locked in a secure cupboard, each strength was kept in a separate lockable drawer.
- All batch numbers were recorded during the 'World Health Organisation' surgical safety checks in the procedure room. Contrast was used as a material to examine blood vessels in key areas of the body for abnormalities such as aneurysms, an aneurysm is a bulge in a blood vessel caused by a weakness in the blood vessel wall, usually where it branches. As blood passes through the weakened blood vessel, the blood pressure causes a small area to bulge outwards like a balloon. Patient contrast dose was audited every three years and information gathered was reviewed by a medical physics expert.

Incidents

- **Staff recognised incidents and reported them when they felt it was appropriate. Managers investigated incidents and shared lessons learned with the team and the wider service. Staff we spoke with felt they were listened to. Staff we spoke with were 'open' and 'honest' and apologised to their patients when things went wrong.**
  - Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From December 2017 to December 2018, the service reported zero incidents classified as a never event
  - From November 2018 to March 2019 the unit reported 30 incidents. Some themes were around clinical documentation incident, medicine incident and post-operative complication. No radiation incident was reported to CQC.
  - Staff we spoke with were clear on how to raise and report incidents. Staff were aware of their responsibilities in raising concerns, recording safety incidents, and near misses.
  - The service manager told us that all incidents relating to InHealth were involved in a robust process and any recurring trends were identified, shared and any lesson learned were shared with staff at a monthly user group meeting.
  - Staff demonstrated how they accessed the electronic reporting system. InHealth staff were required to dual report incidents on the host hospital and InHealth reporting system. All incident reports were reviewed and investigated by the service manager, and action plans were put in place when required. The service manager we spoke with showed us how they used their local 'complications register' including any reporting complications that occur on the unit.
  - Senior staff told us the host hospital carried out regular audits to identify learning and review practice following submissions through the electronic reporting system by the host hospital, which were reviewed by their own clinicians.
  - Staff were able to demonstrate good understanding around duty of candour. Duty of candour is a regulatory duty that relates to 'openness', 'honesty' and 'transparency' and requires providers of health and social care services to notify patients or other relevant person(s) of certain notifiable safety incidents and provide reasonable support to that person.
  - The management team explained that duty of candour lies with both InHealth and host hospital. The service manager's role was to facilitate an apology and

implement actions to mitigate recurrence. A thorough investigation was undertaken following a reporting incident and a subsequent discussion held at a weekly internal governance meeting.

Safety Thermometer (or equivalent)

- The service collected data on the performance relating to the cardiac catheter laboratory procedures. This was collected at corporate level and reported in a performance monthly dashboard.
- The service reported no patient harm incidents September 2017 to January 2019

Are diagnostic imaging services effective?

We did not rate effective.

Evidence-based care and treatment

- **The service used current evidence-based guidance and quality standards to inform the delivery of care and treatment. Local and national audits such were completed, and actions were taken to improve care and treatment when indicated.**
  - Policies we looked at were accessible, current and referenced good practice guidelines and where relevant, referred to professional body guidance and published research papers; for example, the WHO checklist, Safeguarding policy.
  - We saw that the clinical effectiveness of procedures and compliance with clinical pathways and benchmarking with other InHealth services and was reviewed and assessed within the monthly clinical governance meetings.
  - Guidance from the National Institute of Health and Care Excellence and Royal Colleges was disseminated to appropriate specialities, and we saw these were on display within the unit. We saw InHealth service had systems in place to provide care and treatment in line with best practice guidelines such as National Institute for Health and Care Excellence (NICE) guidance: Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital. For example: an early warning score system was used to alert staff should a patient's condition start to deteriorate.
  - Radiographers followed evidence-based practice based on protocols for carrying out their duties.
  - Managers updated staff when new guidelines were introduced, staff were expected to sign to confirm understanding.
  - We saw a range of standard operating procedures for staff to follow, for example the management of monitoring of radiation doses.
  - Staff were able to show us how they accessed clinical guidelines and local policies on their intranet page.

Nutrition and hydration

- **Staff monitored patients' nutrition and hydration needs.**
  - Staff offered drinks to patients on a regular basis throughout the day, patients we spoke with said staff were very attentive.
  - Drinks machines, water fountains and snacks were available in the adjacent café area located in the main department at the host hospital.
  - Dietary requirements were established during pre-assessment and then met on the day of procedure.
  - Senior staff told us for patients who were diabetic, their treatment time was coordinated to maintain a normal blood glucose level.

Pain relief

- **Staff assessed and managed pain on an individual basis and regularly monitored throughout patient care.**
  - Analgesia was offered and given appropriately using the five rights of medicine administration, one of the recommendations to reduce medicine errors and harm was to use the "five rights": the right patient, the right drug, the right dose, the right route, and the right time.
  - Staff tried to make patients as comfortable as possible during their procedure and post operatively. Patients we spoke with said staff were very caring and offered pain relief when necessary.
  - Staff were trained to assess patient's experience of pain, which was crucial in providing effective pain

management. A systematic process of pain assessment, measurement and re-assessment, enhanced the health care teams' ability to reduce pain and achieve comfort.

- We saw staff at regular intervals asking patients if they required pain relief. Patients were assessed for pain using a scoring tool and pain relief was given as needed. This was recorded in patient notes.

Patient outcomes

- **The service monitored the effectiveness of care and treatment and used the findings to improve them.**
  - The service had a comprehensive audit programme, this included local, regional and corporate audits. These were aligned to evidence-based practice and national guidance where appropriate. Where patient outcomes did not meet national targets, the unit introduced action plans to improve such VTE, cannulas, WHO safety surgical checklist, and unplanned return to theatre, or cancellations of procedure.
  - Following a procedure, the consultant cardiologist responsible for the care of the patient completed the outcome of the procedure on the host hospital reporting system. In an event of complications during a procedure, this was reported in the InHealth complications log. A review of complications was subsequently completed quarterly and shared at a monthly user group meeting.
  - A senior manager told us that monthly multidisciplinary meetings were held with the consultant cardiologist to review outcomes for both elective and non-elective procedures including patients that required onward referrals for a percutaneous coronary intervention (PCI) procedures at a tertiary centre. Percutaneous Coronary Intervention (PCI, formerly known as angioplasty with stent) is a non-surgical procedure that uses a catheter (a thin flexible tube) to place a small structure called a stent to open blood vessels in the heart that have been narrowed by plaque build-up, a condition known as atherosclerosis. All PCI data was submitted into the Myocardial Ischaemia National Audit Project (MINAP) for Regional and National Benchmarking.

Competent staff

- **Staff had the skills, knowledge, and experience to deliver safe care and treatment. Staff were appraised annually, staff told us they found appraisals to be useful and they were encouraged to identify any learning needs they had.**
  - Staff told us that new staff to the unit were given a tour of the premises on the first day. Orientation of the unit took place for bank staff and agency staff who had previously worked at the unit, this was to ensure any changes were shared with staff.
  - Clinical staff were supported by a comprehensive competency assessment toolkit, which covered key areas such as use of equipment and any applicable assessment across all roles. Staff were also expected to pass a probation period depending on the skills of the staff.
  - Nurses were rotated from day ward and the cardiac catheterisation laboratory, this ensured clinical competencies were maintained.
  - The recruitment process ensured that staff had the right qualifications, skills, knowledge and experience to do their job when staff start their role.
  - Ongoing staff competency was managed through a performance review process. Clinical staff were also expected to complete Clinical Professional Development (CPD) to meet their professional body requirements. Staff we spoke with told us they felt supported to maintain CPD and engage with the revalidation processes.
  - Consultant competencies were assured through the NHS annual appraisal and the General Medical Council (GMC) revalidation process. All consultants must have an annual appraisal by an approved appraiser to maintain practising privileges at InHealth.
  - There was a process in place within the department to monitor and arrange appraisal dates for staff. Staff told us their appraisals were a helpful and a good way to raise any concerns, training and development requirements.
  - Staff we spoke with told us they had a discussion with their manager during their quarterly appraisal and were able to identify any training needs. Appraisal rates were at 100%.

- The unit had a competency framework that included contrast media pressure injector, radiographer led coronary artery angiogram and practical safety. All competency frameworks provided clear documentation, evidence of observations and actions taken.
- We reviewed doctor's documentation working at the unit, we saw IR(ME)R certificates and radiation protection training certificates and found them to be in date.

Multidisciplinary working

- **The multidisciplinary team worked well together to support patients holistically; doctors, nurses, radiographers, physiologist and other healthcare professionals supported one another to provide good care.**
  - The team at the unit worked well with their colleagues at the host hospital. This provided a continuous pathway for patients.
  - Staff worked effectively as a multidisciplinary team (MDT). All health professionals worked as one team to ensure patients' needs were met.
  - Specialist services were requested when required such as social services, psychological support and learning disability teams to promote a holistic approach to any health condition management. Staff also told us they had access to additional support from pharmacy, physiotherapists, and other specialist services. Other services provided support on an on-call basis. These services were referred through the host hospital referral systems.
  - We saw good interactions between radiographers, medical staff, nursing staff and physiologist during a procedure to ensure the patient received the best possible treatment.
  - The unit had a joint clinical pathway with consultants cardiologist with host hospital and local acute hospital service. Pathways supported staff in decision making and informed staff on appropriate referral pathways.

Seven-day services

- **The unit was open to provide care for the local population on three days a week.**
  - The unit was operational on Tuesdays and Thursdays 7.30am until 6pm and Friday mornings 7:30am until 2:30pm.
  - Pre-assessment clinics were running on Wednesdays 8:30am until 5pm.

Health promotion

- **Health promotion materials were available throughout the unit and staff knew which services to signpost patients to.**
  - Information leaflets in the waiting room were available for patients to read. Leaflets detailed information about what to expect during the procedure.
  - We observed literature about range of cardiac and other health related conditions such as diabetes, chest conditions, heart failure and healthy eating, smoking cessation and exercise classes in the local area.
  - In the waiting area we saw posters on display specific on health promotion activities and infection prevention messages.

Consent and Mental Capacity Act

- **Staff demonstrated awareness of consent, the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS).**
  - Staff understanding around the principles and values that underpinned the legal requirements in the Mental Capacity Act 2005 and Deprivation of Liberty safeguards was evident. For example, that a person must be assumed to have capacity unless it was established they lacked capacity.
  - Before any interactions were undertaken, we observed staff gaining consent throughout our inspection. We saw good documentation around the recording of consent in patient records.
  - Staff were able to demonstrate good understanding of capacity. Patients were consented on the day of procedure by the consultant cardiologist including a comprehensive assessment to check if patient understood what they were consenting to.

Are diagnostic imaging services caring?

Good

Diagnostic imaging

Good

We rated it as **good.**

Compassionate care

- **Staff cared for patients with compassion and respect. Patients feedback and those close to them throughout our inspection was positive. Staff treated patients with dignity, respect and empathy.**
  - Staff introduced themselves before any interactions with patients; we observed staff to be respectful, polite, and friendly.
  - Staff demonstrated a courteous and compassionate manner towards all patients and their families, we saw this reflected in the feedback from Friends and Family questionnaire, 98% of patients would recommend this service.
  - Staff who undertook the pre-assessment clinics were the same staff who cared for those patients during their procedure. Staff were passionate about this process as they could offer continuity and support for their patients. This ensured some reassurance for their patients.
  - There were dignity curtains around the preparation area which separated patients on the day ward. This meant patients dignity was further protected and we observed curtains were kept close during any consultations.
  - The unit had a chaperone policy, patients were offered a chaperone if they wished. This request was documented in patients' medical notes if they required a chaperone along with a completed chaperone consent.
  - We spoke with patients and their relatives who provided positive comments regarding the care given by all levels of staff. Patients told us that staff spoke kindly and respectfully towards them; and took time with care and treatment.

Emotional support

- **Patients' emotional and social needs were considered as important as their physical well being.**
  - Pre-assessment documentation we reviewed showed that cultural, social and religious needs were identified during pre-assessment and addressed accordingly.
  - Staff supported patients through their procedure, ensuring they were well informed and knew what to expect.

    Patients told us they were kept up to date if the unit was running behind, some patients we spoke with had used this service before and said they wouldn't go anywhere else.

Understanding and involvement of patients and those close to them

- **Patients who used the service and those close to them were active in their care and treatment.**
  - All patients we spoke with told us they felt informed about the procedure and were involved in decision making prior to treatment. The details of the procedure, the precautions and what would happen was fully explained to patients and their relatives during their pre-assessment appointments. Patients also confirmed they had received a written information detailing all relevant information to them.
  - Staff told us that pre-assessments were scheduled with enough time during the clinic to allow patients to raise any queries or concerns and often these were addressed prior to procedure day.
  - Staff completed equality and diversity mandatory training, this allowed staff the opportunity to provide more individualised, patient centred care.

Are diagnostic imaging services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- **Patients' needs, and their preferences were considered and acted upon to ensure services were delivered and accessible in timely manner. The service planned and delivered services to meet the needs of people using the service.**

Good

Diagnostic imaging

- The unit encompassed a waiting area with five chairs and one high armchair for the elderly or patients with reduced mobility and one for their family/friends, one cardiac catheterisation laboratory equipped with imaging equipment and a six-bedded day ward (divided into two sections with separate entrances to allow for single gender accommodation).
- The unit provided a separate toilet facility for male and female, which had access for those with reduced mobility. The unit also had a changing room with toilet and locker facilities for staff, along with a small kitchen providing hot and cold water, refrigeration and storage for staff food.
- The service had a large variety of patient information leaflets in several different formats such as large fonts, different languages available on the unit, and their website to provide useful information for patients.
- Staff told us bariatric beds, or chairs (for patients living with obesity) could be ordered from stores, staff would bleep the host hospital switchboard for a porter to deliver. Maximum table weight in the laboratory treatment room was at 200 kilograms, if the patient exceeded the weight patient would be transferred to another tertiary unit.
- Managers told us that any changes to the unit were dictated by the host hospital in accordance with the needs of the local population. Service delivery considered the needs of different people and worked very closely with the host hospital to ensure patient needs were effectively met.
- The procedures performed at the cardiac catheterisation laboratory were restricted to cardiac angiography and noncomplex pacing only. Patients requiring angioplasty and complex pacing procedures were referred to neighbouring tertiary hospitals.
- Patients requiring onward care were transferred on the same day of their diagnostic procedure using a local ambulance service or discharged home and referred for a staged procedure depending on the severity of their condition following consultant discussion and decision. We saw the unit had an agreed pathway in place for emergency transfer from the coronary care unit.
- Following from an outpatient cardiology clinic appointment, patients were offered a pre-assessment appointment within one to two weeks and an elective procedure date within one to two weeks. Staff told us that urgent pre-assessment and procedure appointments were offered to patients requiring urgent treatment, all audits were gathered by the host hospital and shared with their local CCG. Patients we spoke with told us they did not have to wait long for their appointment and were seen promptly.

Meeting people's individual needs

- **Staff had access to interpreters to aid communication with their patients. Patient's needs were considered when delivering and coordinating services, including those who were vulnerable and had complex needs.**
  - We observed staff answering patient call bells in a timely manner.
  - Patients used a telecom at the entrance door to inform front house staff of their arrival. Staff greeted patients in the waiting area.
  - There was a large notice board in the waiting area that gave information about local interpreters. Staff told us they used professional interpreters rather than relying on family members to interpret messages. This ensured information given to patients was clear and mitigated risks of any misunderstanding.
  - Care planning for patients with complex needs such as patients living with dementia or a learning disability commenced at pre-op assessment. Staff told us that a multi-disciplinary planning meeting was held if required prior to treatment. The unit welcomed family member or friend to support patient during procedure if this was to help the patient.
  - Patients with learning disabilities or those who were anxious were offered a unit tour prior to treatment and to familiarise themselves with the unit and staff. The service aimed to have the same nurse carrying out the pre-assessment to be the nurse looking after the patient either during procedure or in recovery.
  - The unit met the needs of patients who required wheelchair access. Access to the building, toilet facilities and the clinical area were easily accessible.

Good

Diagnostic imaging

- The unit team were identified in photographs on the units display boards. These were visible to all staff and patients. This meant that people could identify who staff were.

Access and flow

- **Access to care was managed to take account of patients with high risk needs. Patients had access to the right care at the right time.**
  - Management staff we spoke with told us that on routine operational days, the service ran on time and any disruptions were communicated effectively with patients. Patients we spoke with confirmed this. We saw evidence that demonstrated the unit had exceeded their national targets continuously for patient arrival time to hospital to procedure. This information was shared with their local clinical commissioning group (CCG).
  - Patients received access to the service and test results in a timely way. The service managed this by performing all examinations in order of clinical priority.
  - The host hospital booking team schedule pre-assessment appointments for patients undergoing procedures in the InHealth cardiac catheterisation laboratory.
  - The service manager told us they reviewed the pre-assessment wait list weekly with the chest pain unit lead to ensure capacity was adequately available and patients were booked within the required time scale to avoid unnecessary delays.
  - Staff told us an additional pre-assessment clinic day was held for patients approaching their procedure date who had not yet been seen at pre-assessment clinic, the unit offered additional clinics to support the fluctuating demand of the service.
  - The service reported zero cancellation of procedures or examinations in the reporting period of December 2017 to December 2018 and four patients were delayed due to equipment failure.

Learning from complaints and concerns

- **Patients concerns, and complaints were investigated, lessons were learned from complaints and shared with all staff, complaints were dealt with in a timely manner.**
  - Staff we spoke with during our inspection told us that InHealth reviewed all complaints, concerns and incidents on a weekly basis during a weekly multidisciplinary 'Complaints, Litigation, Incidents and Compliments' Group, ensuring that complaints were robustly investigated, and learning were shared throughout the unit.
  - The service had a clear complaints process, a complaint handling procedure and policy which staff followed. InHealth aim to acknowledge all complaints within three working days and investigate and formally respond within 20 working days. InHealth operated a three stage complaints management policy.
  - The unit received 180 compliments and zero complaints in the last 12 months. Patients we spoke with knew how to raise complaints, we also saw information leaflets were available in the waiting area.

Are diagnostic imaging services well-led?

Good

We rated it as **good.**

Leadership

- **Managers of all levels within the service had the right skills and abilities to run a service providing quality and sustainable care.**
  - A clinical lead, operations manager and service manager led the cardiac catheter laboratory unit. The cardiac catheter laboratory was part of the medicine and diagnostic services group, which included support from the host hospital an integrated health and social care team.
  - The angiography service manager led the unit daily. The senior nurse was responsible for the nurses and the HCA team. They were visible and approachable.
  - There were a number of up to date information posters on display boards for staff in the unit such as IR(ME)R updates, NICE guidelines and any information relating InHealth. The service manager was responsible for keeping the boards up to date with useful information. This meant that staff could, at a glance, be kept up to date.

- The service had managers at all levels with the mix of skills and abilities to run the service. Staff felt supported in their roles and felt they had opportunities for training and further development within their role.
- All staff we spoke with told us that managers were visible and approachable, they encouraged an open-door policy that promoted a close working relationship.
- Managers told us InHealth provided a bespoke leadership and development programme for first line operational and service managers. Senior staff we spoke with felt supported within their role.
- Staff we spoke with felt empowered to take accountability for the services they provide and felt supported to grow and develop ideas and practices that will improve patient and organisational safety.
- Staff told us the executive team communicated through their weekly newsletter, all staff knew who the executive teams were and said some members of the team had visited the unit.

Vision and strategy

- **The service had a vision of what it wanted to achieve and plans to turn it to action. Staff were aware of the vison and values and staff we spoke with were able to demonstrate the values within their role.**
  - InHealth shared their vision 'to make healthcare better', through a set of four values of Trust, Care, Passion and Fresh Thinking.
  - Staff told us they were introduced to the vision and values of InHealth during their corporate induction within the first three months of employment.
  - The service vision was aligned to both InHealth strategy and the local plans of the host hospital.
  - Staff were aware of the host hospital vision and values and their own service visions and were frequently kept up to date with any changes within their own unit.
  - Staff we spoke with were committed in providing safe care and improving patient experience. We observed staff to be safe, kind and caring and patients were at the centre of all they did.
  - There was a positive culture of staff development and empowerment which was supported and encouraged by all managers we spoke with.

Culture

- **Managers at the unit promoted a positive culture that supported and valued their staff with shared values on patient care and improving the quality of care within their service.**
  - The culture at the unit was open and transparent. Staff we spoke with told us they felt valued and respected and enjoyed working at the unit.
  - We saw effective communication from the corporate team, staff felt informed about various issues that occurred across other sites from incidents, to training updates. Information was communicated in newsletters, team meetings and emails.
  - Staff felt they could raise concerns if they needed to and felt assured these would be addressed appropriately.
  - We observed staff working well together, sharing information and knowledge. Staff told us they could approach any of their colleagues for professional advice and they were not made to feel less knowledgeable.
  - Staff worked well as a team, we saw many examples where staff were very caring towards one another especially during busy times.
  - Senior staff said they would always support staff where they could.
  - Staff were proud of the service they delivered and spoke positively about the unit and the team. There was constructive engagement with staff.

Governance

- **The governance arrangements were clear and operated effectively and staff understood their roles and accountabilities.**
  - Governance processes were in place, handover meetings, team meetings and managers meetings were fed back into the medicine governance meetings that were held monthly.
  - Senior managers told us that InHealth ensure that 'Board to Floor' awareness of issues and safety concerns were achieved through governance

committees and working groups led by the risk and governance committee. We found the service used governance, risk management, and quality measures to improve patient care. Both safety and outcomes were effectively monitored. Any concerns we raised during our inspection were acted upon immediately and the risks were mitigated efficiently and effectively. We were assured that the services leadership were managing risks robustly.

- We reviewed the two months governance meeting minutes for November 2017 and January 2018. On the agenda they discussed incidents, annual audit plan, NICE guidelines updates, shared learning, Health and Safety. We saw these meetings were well attended by a range of multidisciplinary staff.
- The service carried out local audits and used the outcomes to improve local delivery of services. Outcomes from audits highlighted what we're working well, and where they could improve.
- Operation manager had the experience required for overseeing the operational management of the unit. The operations manager had completed the professional development programme to enhance their leadership and mentorship skills to support staff and the unit. We were told by the service manager that they were enrolled to the programme April 2019.
- Senior staff told us they had monthly meetings, where they discussed safeguarding, mandatory training, incidents, complaints/compliments, and learning from legal and root cause analysis updates. Minutes from meetings and unit dashboard with performance data were shared with staff within the department. The service had a close relationship with the host hospital, which allowed for some cross over in governance processes such as safeguarding and incident reporting.

Managing risks, issues and performance

- **The service had a system in place for identifying risks, planning to eliminate and reduce risks and the ability to cope with expected and unexpected challenges within the service.**
- We could see that the risks identified in the risk register were areas of focus. We saw the risk register for the service accurately reflected the main risks to the department. Senior staff reviewed the risk register each month both at a divisional and local level and risks were appropriately adjusted.
- The service had a risk assessment system in place locally with a process of escalation onto the functional and corporate risk register. The local risk register was reviewed and updated quarterly or when a risk was identified. We saw an example where a new risk for the physiologist role, the unit currently has one in post, if this staff member were to fall ill, the unit would find it difficult to cover, and added to the local risk register.
- The unit performance was monitored on a local and corporate level, reports were produced which enabled overall comparisons and benchmarking against other icardiac catheterisation laboratory services. The service monitored a range of performance indicators such as turnaround times, patient engagement, incidents, complaints and mandatory training.
- We reviewed three months of Key Performance Indicators for the unit November 2018 to January 2019 and saw the unit were performing beyond their targets at 100%.
- We reviewed the service's corporate business continuity plan for February 2018 to February 2021. The Purpose of the Corporate Business Continuity Plan (BCP) was to prepare a business for the effects of extended service outages caused by factors beyond the services control for example natural disasters, to protect business critical processes and counteract interruptions to business activities; enabling the restoration of services to the widest extent possible in the minimum time frame, whilst maintaining effective communication with key stakeholders. Managers we spoke with were able to explain the business plan and the information were well embedded amongst the management, and team were aware of their roles.

Managing information

- **Management collected, analysed, managed, and used information to support activities using secure systems with security to safeguard all processes in use.**
- Unit managers were responsible for cascading information upwards to the management team. We saw

information were shared during clinical governance Complaints, Litigation, Incident, and Compliments ('CLIC') meetings. There were adequate number of computers in the unit for staff to carry out their duties.

- The unit had two separate electronic system one specific for InHealth and one for the host hospital. This meant information could be shared easily across sites, but staff told us a lot of this duplicated their work and very repetitive.
- We reviewed team meeting agendas including meeting minutes for October 2018 and January 2019. Areas for discussions included audits, appraisals, friends and family feedback and turnover times.
- All confidential information, images and communications used were secure, and could only be accessed using a password, key coded pass or swipe card. Each staff member had their own unique password.

Engagement

- **Staff engaged well with patients, staff, and the public and local organisations to plan and manage appropriate services and collaborated with partners' organisations effectively.**
  - The operations manager told us following a patient experiences week in April 2018, feedback received identified improvements were required in the patient waiting area of the unit. Measures were put in place and implemented to ensure the environment was more patient friendly and since then the waiting area provided magazines, patient feedback results on display and health promotion materials.
  - The service manager met with service leads to discuss issues or risks at the unit. The unit engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with host hospital effectively.
  - Senior staff told us that InHealth were at an early stage of independent sector adopter of NHS England's 'Always Events' methodology, working with patients to co-design services and information resources that meet individual needs.
  - According to NHS England an' always event' must meet four criteria: (1) t: Patients and family members have identified the event as fundamental to improving their experience of care, and they predict that the event will have a meaningful impact when successfully implemented. (2) : The event is known to contribute to the optimal care of and respect for patients and family members (either through research or quality improvement measurement over time). (3) : The event is specific enough that it is possible to determine whether the process or behaviours occur reliably. This requirement is necessary to ensure that Always Events are not merely aspirational, but also quantifiable. (4) : The event should be achievable and sustainable without substantial renovations, capital expenditures, or the purchase of new equipment or technology. This specification encourages organizations to focus on leveraging opportunities to improve the care experience through improvements in relationship-based care and in care processes.
  - Senior managers told us that InHealth were involved with the patient engagement network (PEN) for the cardiac modality, the results of which had facilitated improvements in parts of the patient pathway.

Learning, continuous improvement and innovation

- **The service was committed in improving services by learning from things that have gone well and when things go wrong, promoting training, research, and innovation.**
  - During our inspection, staff told us the host hospital was due to merge with another hospital becoming a university hospital. Staff told us about ongoing discussion regarding the cardiac catheterisation laboratory and potential of increasing its operational days to support the other hospital.
  - The host hospital was currently in the early stages of applying for the British Cardiovascular Intervention Society (BCIS) accreditation to undertake Percutaneous Coronary Intervention (PCI), following receipt of on-going feedback from patients requesting this to be provided locally. InHealth were working towards a tender application to the local CCG to ensure they were the chosen service to be able to provide this service for the NHS trust.