The London Heart Centre Ltd

Quality Report

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Date of inspection visit: 06 November 2018
Date of publication: 07/02/2019

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	Inadequate
Are services safe?	Inadequate
Are services effective?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Inadequate

Overall summary

The London Heart Centre Ltd is operated by The London Heart Centre Ltd. The centre opened in 1978 and has been managed by The London Heart Centre Ltd since 2007. The service offers diagnostic tests for adults and young people.

Patients are offered electrocardiogram (ECG) and stress echocardiography (stress echo) services. The service had two diagnostic imaging rooms in the basement and a consultation room on the ground floor.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 06 November 2018.

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.

Summary of findings

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

Services we rate

We rated it as inadequate overall.

- The service did not have an effective leadership structure including staff with the right skills and abilities to provide high-quality sustainable care.
- The service did not have an effective system to improve service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- Policies and procedures were not reviewed regularly and updated where required.
- There were no clear lines of accountability and responsibility for completing the action plans from the governance audit, and Legionella and fire risk assessments.
- There was no identifiable escalation policy for urgent findings or deteriorating patients.
- The service did not comply with its recruitment policy to ensure all checks were completed prior to employment.
- The service did not have a risk management strategy, setting out a system for continuous risk management.
- The service did not actively engage with patients, staff, the public and local organisations to plan and manage appropriate services.
- The service did not show commitment to improving services by learning from when things went well or wrong, promoting training and innovation.
- The service did not provide adequate mandatory training in key skills to all staff. The service did not have a mandatory training policy or document that set out what skills were required to perform individual tasks.
- Staff did not have adequate training on how to recognise and report abuse. Not all staff members understood how to protect patients from abuse, the relevant organisations to report to and their contact details.
- The service was not registered to receive safety alerts
- No health and safety risk assessment of the premises had been undertaken.

However, we also found the following areas of good practice:

- The service controlled infection risk well. Staff kept equipment and the premises clean and adhered to infection control and prevention methods.
- The service had suitable premises and equipment and maintained them well.
- The service provided care and treatment based on national guidance. Managers checked to make sure staff followed guidance.
- Staff of different grades worked together as a team to benefit patients. Doctors 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.
- The centre had a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with four requirement notices that affected London Heart Centre Limited. Details are at the end of the report.

'I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.'

Nigel Acheson

Summary of findings

Deputy Chief inspector of Hospitals (London and the South East)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Inadequate 	We rated the service as inadequate: The service did not have an effective leadership structure including staff with the right skills and abilities to provide high-quality sustainable care. The service did not have an effective system to improve service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish. The service did not have a risk management strategy, setting out a system for continuous risk management. The service did not show commitment to improving services by learning from when things went well or wrong, promoting training and innovation.

Summary of findings

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Summary of this inspection

Background to The London Heart Centre Ltd

The London Heart Centre Ltd is operated by The London Heart Centre Ltd. The London Heart Centre Ltd is operated by The London Heart Centre Ltd. The centre initially opened in 1978 and was taken over by The London Heart Centre Ltd in 2007. The service offers diagnostic tests for adults and young people. The centre primarily serves the communities of greater London. It also accepts patient referrals from outside this area.

The centre has had a registered manager in post since 2013.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in diagnostic imaging services.The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Information about The London Heart Centre Ltd

The London Heart Centre Ltd is operated by The London Heart Centre Ltd. The service offers diagnostic tests for adults and young people. Patients are offered access to electrocardiogram (ECG) and stress echocardiography (stress echo) services that help with diagnosis and management of heart conditions.

The service is registered to provide the following regulated activities:

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

The centre had two diagnostic imaging rooms in the basement, and a consultation room on the ground floor. The service had two ECG machines, a stress echo machine, 24-hour ECG and blood pressure monitoring kits and an arrhythmia monitoring kit.

During the inspection, we spoke with six staff including; medical staff, reception staff and senior managers. During our inspection, we reviewed five sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once in December 2013 which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (November 2017 to October 2018)

- In the reporting period November 2017 to October 2018 there were 1,897 diagnostic imaging tests.

Four cardiologists, two cardiac physiologists, two receptionists and the registered manager worked at the service.

Track record on safety

- No Never events
- No serious injuries
- No complaints

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?

Inadequate

We rated safe as inadequate because:

- The service did not provide adequate mandatory training in key skills to all staff. The service did not have a mandatory training policy or document that set out what skills were required to perform individual tasks.
- Staff did not have adequate training on how to recognise and report abuse. Not all staff members understood how to protect patients from abuse, the relevant organisations to report to and their contact details.
- The service had not risk assessed the emergency medicines and equipment to ensure it was in line with guidance issued by the Resuscitation Council. We checked the automated external defibrillator (AED) and when the unit was switched on it indicated a 'low battery error'.
- The service was not registered to receive safety alerts
- No health and safety risk assessment of the premises had been undertaken.
- Action plans from the Legionella and fire risk assessment had not be completed.
- The service did not have an up to date medicines management policy.
- The service did not manage patient safety incidents effectively.
- The service did not have a duty of candour policy. Staff we spoke with did not understand the duty of candour requirements.

However, we also found the following areas of good practice:

- The service controlled infection risk well. Staff kept equipment, and the premises clean.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- 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.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.

Are services effective?

We do no rate effective, however we found;

Summary of this inspection

- All local policies were written in 2013 for review in 2014. The policies had not been reviewed and did not reference up to date legislation or best practice guidance.
- The service did not have an equality and diversity policy.
- There was no identifiable escalation policy for urgent findings or deteriorating patients.
- Staff did not have regular appraisals.
- Staff files did not have evidence of current professional registration and medical indemnity insurance.
- Not all staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The service did not have a policy and procedure for when a patient could not give consent.

However, we also found the following areas of good practice:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff of different grades worked together as a team to benefit patients. Doctors and other healthcare professionals supported each other to provide good care.
- Managers monitored the effectiveness of care and treatment.

Are services caring?

Good

We rated caring as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- The receptionist assisted patients promptly and were friendly and efficient.
- The centre had a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff communicated with patients so that they understood their care, treatment, and condition.

Are services responsive?

Good

We rated responsive as good because:

- Patient's individual needs and preferences were central to the planning and delivery of the service. The services were flexible and provided choice.
- The service provided planned diagnostic tests for patients at their convenience.

Summary of this inspection

- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to the diagnostic tests were in line with good practice.
- Staff understood the impact that patients care, treatment and condition had on their wellbeing.

However, we also found the following issues that the service provider needs to improve:

- Information on how to make a complaint was not readily accessible to patients.
- The service did not have access to an interpreter for patients whose first language was not English.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- The service did not have an effective leadership structure including staff with the right skills and abilities to provide high-quality sustainable care.
- The service did not have an effective system to improve service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- Policies and procedures were not reviewed regularly and updated where required.
- The service did not have regular staff meetings.
- There were no clear lines of accountability and responsibility for completing the action plans from the governance audit, Legionella, and fire risk assessments.
- The service did not comply with its recruitment policy to ensure all checks were completed prior to employment.
- The service had not undertaken infection control or hand hygiene audits.
- The service did not have a risk management strategy, setting out a system for continuous risk management.
- The service did not adequately collect, analyse, manage, and use information well to support all its activities, using secure electronic systems with security safeguards.
- The service did not actively engage with patients, staff, the public and local organisations to plan and manage appropriate services.
- The service did not show commitment to improving services by learning from when things went well or wrong, promoting training and innovation.

However, we also found the following areas of good practice:

Summary of this inspection

- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff and patients
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Inadequate

Diagnostic imaging

Safe	Inadequate
Effective	
Caring	Good
Responsive	Good
Well-led	Inadequate

Are diagnostic imaging services safe?

Inadequate

We rated it as **inadequate.**

Mandatory training

- The service did not provide adequate mandatory training in key skills to all staff. The service did not have a mandatory training policy and it was unclear what mandatory training staff were required to complete.
- The service had four cardiologists, a registered manager, two physiologists and two receptionists. We checked the mandatory training records for all staff. The service did not have evidence of mandatory training such as basic life support, infection control, manual handling, fire safety, confidentiality, and mental capacity.
- The cardiologist told us mandatory training had been completed with their substantive NHS employer. No evidence of this training had been provided to the service. The service did not have a practicing privileges policy to show how assurances regarding mandatory training would be provided.
- The service did not have mandatory training records for the physiologists. Records provided by the service showed that the registered manager and two receptionists had completed mandatory training.
- Staff showed us a new training matrix that would be implemented. The training matrix had a list of mandatory training courses, the date the course would be completed and when the training should be renewed. However, there was no date set for implementation.

Safeguarding

- Staff did not have adequate training on how to recognise and report abuse. Not all staff members understood how to protect patients from abuse and the relevant organisations to report to and their contact details.
- The service did not have an up to date safeguarding children and vulnerable adult's policy. The safeguarding policy was dated February 2014 and due to be reviewed in February 2015. Staff told us the policy was in the process of being updated. There was no named safeguarding lead and the policy did not contain the relevant contact numbers to report a concern.
- Staff we spoke with did not know the procedure to raise a concern.
- The service is registered to treat the whole population. Both the registered manager and the cardiologist on duty told us no children or young people under 18 years were seen in the service. Records provided by the service showed a young person aged 17 years had undergone a stress echo on the morning of the inspection.
- Staff told us trainee pilots are young person's 16 to 17 years old who attend the service for diagnostic tests. The service did not have evidence of adequate training in safeguarding children.
- Data provided by the service showed that four staff (44%) had training in both safeguarding children and vulnerable adults level two, three staff did not have training in safeguarding children and vulnerable adults. One clinical member of staff had training in safeguarding children only.
- The registered manager told us safeguarding training would be a part of the new mandatory training requirements. Safeguarding training had been included on the training matrix.

Diagnostic imaging

- We were informed there had been no safeguarding referrals in the previous 12 months.
- Staff told us the chaperone policy was being updated. The chaperone policy, dated April 2018, was generic and had not been adapted by the service.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept equipment, and the premises clean. They used control measures to prevent the spread of infection.
- The premises and equipment appeared visibly clean. Staff told us they were responsible for cleaning the equipment and this was done at the start and end of the day and in between patients. The cardiac physiologist had a procedure for cleaning blood pressure cuffs prior to issue to patients. However, the daily cleaning procedure was not documented and there was no checklist to show completion.
- A contract cleaner was responsible for cleaning the building. There were records to show that the cleaners maintained a regular cleaning schedule.
- The service provided staff with personal protective equipment (PPE) such as gloves and aprons. We observed all staff wore PPE where necessary. We noted all staff adhered to the 'bare below the elbows' protocol in clinical areas.
- Hand-washing and sanitising facilities were available for staff and patients. Alcohol based hand cleaning gels were available for patients and staff to clean their hands. Within the consultation rooms a hand washing sink was available to ensure that hands could be washed before and after patient contact.
- There was an accessible toilet on the ground floor which was visibly clean. Posters prompting appropriate hand washing technique were not displayed. A multi-use towel was available for hand drying although paper towels dispensers were present. Single-use paper towels are more effective and hygienic for hand drying.
- Sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use. We noted the service did not have a sharps injury policy to provide guidance of the management of sharps injury including relevant numbers to contact.
- The service had a contract for the disposal of clinical waste and records showed there were regular collections.
- A Legionella risk assessment had been undertaken in October 2017 and there was an action plan in place. We noted that the action plan had not been signed off to confirm which actions had been completed or the expected date of completion.
- The centre did not have an updated infection control policy. The policy had been written in 2013 and was due to be reviewed in 2014. Staff told us the policy was in the process of being updated.
- The service had not undertaken an infection control or hand hygiene audit. Whilst we observed good hand hygiene during our inspection, audits would provide additional assurances that good practice was consistently upheld throughout the service.
- Data provided by the service showed that three members of the administrative staff had completed training in infection control. There was no evidence to show that clinical staff had completed training.

Environment and equipment

- The service had suitable premises and equipment and maintained it well.
- The diagnostic imaging rooms were all well-equipped including couches and trollies for carrying the clinical equipment required.
- We checked the resuscitation equipment. The equipment appeared visibly clean. Single-use items were sealed and in date and emergency equipment had been serviced. Staff told us resuscitation equipment had been checked daily and was safe and ready for use in an emergency. The service did not have a checklist. We checked the automated external defibrillator (AED) and when the unit was switched on it indicated a 'low battery error'.
- The diagnostic imaging rooms were in the basement and comprised an exercise electrocardiogram (ECG) room and a stress echocardiography (stress echo) room. The service had two EGG machines and a stress echo machine24-hour ECG and blood pressure monitoring kits and an arrhythmia monitoring kit.
- Staff told us all equipment's the centre were serviced annually and maintained by a recognised service team. There was an effective system to ensure that repairs to broken equipment's were carried out quickly so that patients did not experience delays to treatment.
- Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. During our inspection we

checked the service dates for all equipment. The service did not have evidence of maintenance for the stress echo machine in 2017 and 2018. Following our inspection, the service sent us confirmation of servicing certificates for the stress echo machine.

- The service was not registered to receive safety alerts from Medicines and Healthcare Products Regulatory Agency (MHRA) and staff did not know about the yellow card system. The registered manager had received some historical safety alerts from a governance agency. Staff did not know about relevant alerts such as the patient safety alert for medical oxygen cylinders
- One of the directors told us diagnostic tests were being undertaken in the basement which posed a challenge for evacuation in the event of a medical emergency. A health and safety risk assessment had not been completed to determine how this risk could be mitigated. Following our inspection, the service sent us confirmation a risk assessment had been booked for 22 November 2018.
- All electrical items had been tested for safety. An electrical installation check had been undertaken in October 2018 and the results were unsatisfactory. There was an action plan in place for the remedial work.
- The service had a stair lift from the ground floor to the basement. The registered manager told us that all staff had been trained to use the stair lift but no records were available to evidence the training. There was no formal risk assessment undertaken for the use of the stair lift.
- The service had a patient changing room where clean gowns and dressing gowns were stored. Lockable cupboards were available so that patients could store their clothing and belongings during their procedure. There were two changing cubicles. We noted one cubicle contained items for disposal and it was not available to patients. The second cubicle also contained items for disposal and was used for storage. These items detracted from the use of the space for patient changing.
- In the corridor outside patient changing room there was an aged stress echo machine waiting for disposal. This corridor held several large cupboards in which medical consumables were stored; including sharps, which were accessible to the public. These cupboards were not lockable.
- Hazardous substances such as cleaning products were locked away and stored securely. Appropriate Control of Substances Hazardous to Health risk assessments had not been completed.
- There was a combined toilet and shower room used by patients who needed to shower following an exercise stress echo or ECG. The room was visibly clean and a cleaning schedule was on the inside door. We observed the floor was wet and represented a slip, trip, fall health and safety hazard.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- One of the director told us the service only performed non-invasive tests. Patients were risk assessed and the service did not see patients who had advanced heart failure. If a patient presented with elevated risk they were seen by one of the more experienced directors.
- The service had a policy for the emergency management of cardiopulmonary resuscitation.
- The service is in an outpatient setting and performs diagnostic imaging tests for patients with potential cardiac conditions. During the tests patients are put under cardiac stress with exercise (on the treadmill) or with drugs (stress echo) and occasionally patients can become unwell. The service did not have a written procedure for the management of a deteriorating patient. Staff told us that if a patient is unwell or collapses they would call 999 for an ambulance. There was also a system on their desktop's screens annotated by a 'green button'. If clicked, it would alert every active computer in the building to the medical emergency and its location. This ensured that all staff could quickly support with the emergency.
- At inspection the green button system was used by the cardiac physiologist for a patient who collapsed prior to an exercise ECG. The cardiologist and other staff went to support their colleague in their management of the patient. The patient recovered and the team agreed it would not be prudent to continue with an exercise ECG on the day. Staff postponed the procedure and informed the referring clinician.
- There was no identifiable escalation policy for urgent findings or deteriorating patients. The cardiologist told us those cases would be discussed with the referrer and cardiologist's directors for advice.

Diagnostic imaging

- A fire risk assessment had been undertaken in August 2018 and the service was a medium risk. An action plan was in place including staff being trained to use the fire extinguishers and carrying out fire drills. A new fire alarm had been installed.
- Staff could explain the fire evacuation procedure and were aware of where the fire extinguishers were located. We noted that fire extinguishers had been serviced within the last 12 months.
- No health and safety risk assessment of the premises had been undertaken.

Medical staffing

- 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 had four cardiologists, two of whom were directors, and two cardiac physiologists.
- A cardiologist attended the service daily to perform ECG and stress echo. The cardiologists were substantively employed in the NHS and had a written contract with the London Heart Centre to deliver care to their patients.
- The cardiac physiologist role was integral to this service. One of the cardiac physiologist took on a permanent role with the service after working as a locum. Agency cover was arranged for holiday periods. The agency physiologist attended for a full day induction if they have not worked at the service before. Where agency physiologists that are familiar with the service, a half day refresher was undertaken.
- The cardiac physiologist described the training for the agency staff which emphasised local systems which may be unfamiliar to agency staff. There was no written evidence of what should be covered in agency induction and no checklist evidence to show it had been carried out.

Records

- Staff did not keep detailed records of patients' care and treatment.
- On arrival, patients were asked to complete a private patient registration form with their details and payment mechanism either self-pay or private medical insurance.
- Patient records were managed in a way that kept patients safe and protected their confidential and sensitive information from being shared incorrectly. Staff used electronic patient records to record patient's diagnostic needs.
- Any hard copy documents generated by the service, including the private patient registration form and the patient consent form, are scanned into the system. Hard copy documents are then shredded by staff at regular intervals during the day. This process was observed with staff taking care to keep documents private from oversight prior to shredding.
- Diagnostic imaging data was also stored electronically for reporting, reviewing and onward transmission. Staff told us these images were encrypted.
- Electronic records could only be accessed by authorised personnel. Computer access was password protected and staff used individual log-ins. However, at inspection we observed a staff member went to lunch and did not lock the system which meant that patient identifiable data remained on the screen and was potentially visible to non-staff members.
- The service did not have an up to date confidentiality and data protection policy. The policy had been updated in February 2013.
- Staff told us they understood the importance of keeping patient data secure. There was no evidence staff had read or signed an information governance confidentiality statement or similar document to confirm that data security was understood.
- Staff explained that there was a generic log on to the system for one of the cardiac physiologists which was a breach of information governance standards. All members of staff should log on to clinical systems using a unique ID so that a 'footprint' of activity can be traced to an individual. This ensures unauthorised activity or access can be identified and aids investigation of information governance incidents.
- Staff told us told us that if errors in patient identifiable information occur for example, wrong date of birth, then these can be rectified by the cardiac physiologist on the system. This type of error was not considered to be an 'incident' and not raised or recorded as one. The system allowed search by name, date of birth and post code.
- We reviewed five patient records. We found that these had all been fully and clearly completed. Staff explained they ensured a patient's identification was confirmed against three points of patient identity including full

name, date of birth and address. The service had not adapted the MHRA six-point check recommendation. The system of checks is more secure when MHRA six-point recommendations are fully implemented.

- An audit of stress echo records was undertaken between May and July 2018 for patients referred by non-cardiologists. The audit looked at the indication for referral, consent, safety, results review, and the consistency of reporting. Twenty-five sets of records were examined. The service scans consent forms onto the patient's record and the audit found 84% of consent forms were scanned in. The remaining 16% of the consent forms had be shredded before being scanned onto the patient records. The service did not ensure accurate, complete and detailed records were maintained.
- Most of the results of these tests were normal (76%). One abnormal result led to the consultant contacting the referring clinician urgently. The results were accurately reported. Not all consultant reports were available within two days. However, the audit did not state the number of reports that were not completed within two days. The audit concluded that all action plans should be scanned in and all reports should be completed within two days. There was no action plan or timescale to address these issues or indication that a further audit would be repeated to assess improvement.

Medicines

- The service followed guidance when prescribing, giving, recording, and storing medicines. Patients received the right medication at the right dose at the right time.
- The service kept medicines for performing stress echo tests and for managing medical emergencies.
- There was a medicines management policy. The purpose of the policy was to make suitable arrangements for the recording, safe-keeping, handling, and disposal of medicines.
- The medicines cupboards were locked and the key was in door. The medicines cupboard was not secure as only authorised staff should have access to keys. All stock was within expiry.
- Medicines were dispensed to patients prior to the stress echo tests. The cardiologist showed us records of a patient who had a stress echo and the medicines were recorded in the patient record. There was a medicines log sheet with details of the date, medicines dispensed, the quantity, name of the patient and prescriber. The log sheet did not include the batch number or expiry date of the medicine.
- Emergency medicines were kept on the resuscitation trollies. The medicines management policy had not been reviewed in 2014 as written on the policy. The policy listed the medicines that should be available for the management of a medical emergency and for dispensing prior to the stress echo test. Additional medicines were present while others included in the policy were not present. For example, sodium chloride, hydrocortisone, calcium chloride, adenosine, chlorphenamine and magnesium sulphate were available but were not included in the policy. The service had not risk assessed the emergency medicines and equipment to ensure it was in line with guidance issued by the Resuscitation Council.
- The service used 'agitated saline' as a contrast medium for transcranial Doppler, a procedure that is performed by the cardiologist. We were told only a small number had been performed in the previous year. The cardiac physiologist showed us a protocol for the procedure including how to prepare the agitated saline prior to intravenous (IV injection). This had been written in 2003 and had been reviewed since then.
- Fridge temperatures were checked and recorded daily and were within the required range to store medicines safely. Medicines management regulations stated minimum and maximum temperatures of locked medicine refrigerators and ambient room temperatures.
- There was a clear pathway to replenish consumables and avoid to stock depletion. Supplies were replenished frequently to avoid shortages and staff told us that they could request additional supplies if they were low before the next restock.
- There were no controlled drugs (CDs) kept or administered

Incidents

- The service did not manage patient safety incidents effectively. Staff did not always recognise incidents or reported them appropriately. Managers did not always investigate incidents and share any lessons learned with the whole team.

Inadequate

Diagnostic imaging

- Staff did not know about the incident reporting procedure. Issues were raised informally with the registered manager and there was no system of investigating and learning from incidents.
- Staff told us about situations that had occurred which were not considered to be incidents such as patient identification errors, patient deterioration and a patient being rude and abusive towards staff.
- One incident of a staff member collapsing had been recorded in the previous 12 months. A description of the incident had been recorded. The incident had not been investigated to determine if lessons had been learnt.
- The service did not have evidence of training or induction on incident reporting.
- The incident reporting policy had not been updated since February 2013.
- Staff we spoke with did not understand the duty of candour requirements. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Are diagnostic imaging services effective?

We do not currently rate effective for diagnostic imaging.

Evidence-based care and treatment

- The service did not provide and treatment based on national guidance and evidence of its effectiveness.
- Care and treatment was delivered to patients in line with British Society of Echocardiography (BSE) and Royal Colleges guidelines. Staff told us they followed national and local guidelines and standards to ensure effective and safe care.
- All local policies were written in 2013 for review in 2014. The policies had not been reviewed and did not reference up to date legislation or best practice guidance. There was no evidence that staff had read and understood the policies.
- A further set of policies had been provided by an external governance consultant in April 2018. The service had not adapted these policies to fit their local needs and they had not been ratified by the directors.
- The service did not have an equality and diversity policy. Staff told us all patients were treated equally, with dignity and respect. The registered manager showed us the new training matrix which was to be implemented and it included training on equality and diversity.

Pain relief

- Staff assessed and monitored patients regularly to see if they were in pain.
- During our inspection, we did not find any patients who were in pain, or required pain relief.
- Cardiologist discussed pain management in the consultation process for patients if required.
- The cardiologist was also available in the event of a patient requiring a review of their pain management.

Patient outcomes

- The service did not monitor the effectiveness of care and treatment. Records provided by the service did not show that the service used the findings from the monitoring exercise to improve the effectiveness of care and treatment.
- Diagnostic reports were usually made available within 48 hours depending on the urgency of the request and investigation.
- Each cardiologist reported on their diagnostic tests. Images were reported on in time order unless it was clinically urgent which would be flagged.
- An audit of stress echo records was undertaken between May and July 2018 for patients referred by non-cardiologists. The registered manager and director told us most reports were completed within two days. The service could not state what percentage of reports were completed within this period.

Competent staff

- The service did not ensure staff were competent for their roles. Managers did not appraise staff's work performance and had not held supervision meetings with them to provide support and monitor the effectiveness of the service.
- The service did not have evidence of regular staff appraisals. The registered manager told us appraisals were overdue. The cardiologist told us appraisals were completed with their substantive NHS employer. We

checked the staff files for the four cardiologists and found one appraisal that was completed in the previous 12 months. The service did not have evidence of an appraisal for the three-remaining cardiologist.

- The service did not have a practicing privileges policy to describe the responsibilities of the cardiologists and the service. For example, the practicing privileges policy would require all cardiologist to provide the service with evidence of a satisfactory appraisal. The service did not maintain a record of appraisal due dates. The cardiac physiologists had not had an appraisal. The registered manager told us their last appraisal was in 2016 and records of this appraisal could not be provided. The receptionists had not been working at the service for 12 months and as a result appraisals were not due.
- The service did not have an induction procedure or checklist. Staff files did not have evidence of current professional registration and indemnity insurance. Staff competencies had not been reviewed. The service did not have evidence to show staff had the appropriate skills, knowledge and experience to carry out their roles effectively.
- Records we checked did not confirm this as the service did not retain evidence of mandatory training for clinical staff.
- Staff had not identified their own learning developmental areas to increase their knowledge, skills, and experience.

Multidisciplinary working

- Staff of different grades worked together as a team to benefit patients. Doctors and other healthcare professionals supported each other to provide good care.
- Staff we spoke with told us they had good working relationships with the cardiologist. This ensured that staff could share necessary information about the patients and provide holistic care.
- The service received referrals from general practitioners and cardiologist as well as self-referrals. Staff gave us examples of occasions when they liaised with the referrer. For example, to discuss the appropriateness of a test or if a test could not be carried out.
- We heard positive feedback from staff about the excellent teamwork.

Seven-day services

- The service is opened Monday to Friday 9am – 5pm.
- Appointments were flexible to meet the needs of patients, including appointments at short notice.
- Referrals were prioritised by clinical urgency. Staff told us if an urgent referral was made the centre would assess appointments and prioritise patients according to their clinical needs and requirements of the referring practitioner.
- Patients are advised to contact the service in the event of an emergency outside of normal opening hours. The centre manager told us patients could speak to the consultants to discuss any concerns.

Consent and Mental Capacity Act

- Not all staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The service did not have a policy and procedure for when a patient could not give consent.
- The service had a consent form. All patients sign a consent form prior to their procedure and this is scanned onto the system. The records that were reviewed included an attached consent form.
- Staff understood their roles and responsibilities in obtaining consent. This included a patient right to refuse treatment. We saw an example where a patient's refusal was recorded.
- Staff had not received training received training in Mental Capacity Act 2005 (MCA). Staff we spoke with were not aware of their responsibilities. Staff told us that if patients presented with a lack of capacity to consent to the examination that they would raise their concerns with the directors of the service.
- The registered manager showed us new training matrix that would be implemented and this included training on the MCA.

Are diagnostic imaging services caring?

Good

We rated it as **good.**

Compassionate care

- Staff cared for patients with compassion. We did not speak with patients at inspection. Information we received from the service showed patients feedback was positive. Feedback from patients confirmed that staff treated them well and with kindness.

Inadequate

Diagnostic imaging

- We observed staff being kind and compassionate as they put patients and their relatives at ease. Patients were treated with dignity and respect. Staff welcomed patients into the centre. The receptionist assisted patients promptly and were friendly and efficient. The reception staff had name badges with their name and designation but were not wearing them on the day on inspection. The cardiac physiologist wore a name badge with name and designation.
- The service had not completed a patient satisfaction survey in the previous 12 months. Staff told us that they used a patient satisfaction survey and that is was in paper format. Surveys were left on the reception desk so that patients could self-select to complete a survey and return it to staff. No surveys were available on the day of the inspection. The completed surveys that were available for review were from 2013.
- Staff provided five 'thank you' letters written by patients. Patients described staff as efficient, professional, supportive, organised and kind. There was one letter from a patient expressing regret at not being strong enough to travel to see one of the cardiologist who they thought provided them with exceptional care.
- Staff were readily available to act as chaperones when needed. Patients were offered the choice of having chaperones during their diagnostic tests.

Emotional support

- Staff provided emotional support to patients to minimise their distress.
- Patients described that staff communicated well with them and helped them to understand their care and treatment. Staff were fully committed to working in partnership with patients. Staff described how treatment options were discussed with patients and they were encouraged to be part of the decision-making process.
- The centre had a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Patients were actively involved in their care.
- Staff understood the impact that patients care, treatment and condition had on their wellbeing. Staff we spoke with stressed the importance of treating patients as individuals. A member of staff described talking to patients during procedures to put them at ease.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff communicated with patients so that they understood their care, treatment, and condition.
- The feedback letters we reviewed showed patients were involved and understood what they were attending the service for, the types of investigations they were having and the expected frequency of attendance.
- Patients described that staff were thorough, took time to explain procedures to them and they felt comfortable and reassured. Patients felt they were given adequate information.

Are diagnostic imaging services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- Patient's individual needs and preferences were central to the planning and delivery of the service. The services are flexible and provided choice.
- The service provided planned diagnostic tests for patients at their convenience. Staff told us that patients appreciated the accessibility of the service. We observed patients being offered different appointment times.
- The environment was appropriate and patient centred. There was a comfortable seating area, cold water fountain, and toilet facilities for patients and visitors.
- Patients were seen promptly and that patients could book the next available appointment with their chosen cardiologist. Staff told us that patients were seen promptly following referral and there were no waiting lists.
- Patients were provided with appropriate information about their visit.

Meeting people's individual needs

- The service took account of patients' individual needs.
- The service supported patients who were unable to manage stairs to the basement clinical rooms by the

installation of a stair lift. Patients with disabilities, that would prevent them from transferring to the stair lift, were excluded from the service. The stair lift has recently been upgraded and was visibly clean.

- Three members of the administrative staff had attended manual handling training as part of their one-day mandatory training course. The service did not have records to show the clinical staff had completed manual handling training.
- There was an accessible toilet on the ground floor including a call bell. There was a good access to the centre by car and public transport. The reception area was clean and tidy with access to magazines, refreshments and toilet facilities for patients and relatives.
- The service did not have access to a telephone interpreter. Staff told us patients whose first language was not English would attend their appointment with an interpreter. For example, patients who were from the embassies was provided with a suitable interpreter from the relevant embassy. Staff told us the only patients that needed an interpreter was from the embassy.
- The service did not have a procedure for treating patients with a learning disability, dementia or bariatric patients. The service had not considered the needs of these patient groups. Staff told us these patients were not routinely seen at the service.

Access and flow

- People could access the service when they needed it. However, the service did not monitor the waiting times from referral to the diagnostic tests. Staff told us patients received an appointment with 24 to 48 hours.
- Patients were offered a choice of appointment times. The service planned to scan patients at the time of their choice and had a confirmation discussion with the patient about whether they wanted a morning or afternoon appointment.
- Referrals were prioritised by clinical urgency. Staff told us if an urgent referral was made the service would assess appointments and prioritise patients according to their clinical needs and requirements of the referring consultant. These discussions were informal, ad hoc and had not been recorded.
- The service ran on time and staff informed patients when there were disruptions to the service. Staff said all patients were seen promptly and patients rarely had to wait for an appointment. At inspection we observed patients were seen promptly.
- Staff told us patients rarely Did Not Attend (DNA) their appointments. The service did not have a formal DNA policy. Staff told us the administration staff followed up DNA appointments with a telephone call.

Learning from complaints and concerns

- The service had a complaints policy which stated complaints would be acknowledged within two days and investigated within 21 days. It was a three stage complaints process and if patients were not satisfied with the service's response the complaint could be referred to Independent Sector Complaints Adjudication Service (ISCAS) who could provide guidance, assistance and arbitration when necessary.
- One of the directors was the complaints lead and was a member of the Independent Doctors Federation (IDF). Membership of the IDF allows a complaint to be referred to the ICAS.
- Information on how to make a complaint was not readily accessible to patients. For example, patient leaflets or a notice in the reception area.
- The registered manager told us the service had not received any complaints in the previous 12 months.

Are diagnostic imaging services well-led?

Inadequate

We rated it as **inadequate.**

Leadership

- The service did not have an effective leadership structure including staff with the right skills and abilities to provide high-quality sustainable care.
- The service did not have oversight on quality and effectiveness or how the service was managed.
- The leadership of the service was shared between the clinical directors and registered manager. The service had two clinical directors who were responsible for the clinical leadership of the service. At the time of the inspection the registered manager had overall responsibility for the for the day to day running of the

service. The registered manager had a background in accounting and this was their main responsibility. However, the registered manager fully assumed the day to day running of the service when the practice manager left in September 2018. The practice manager was responsible for governance arrangements within the service. A new practice manager with the right skills and abilities to run the service would be recruited. The service had not started the recruitment process.

- Staff knew the management arrangements and their roles and responsibilities. The management team was visible and approachable. We observed members of staff interacting well with the leadership team during the inspection.

Vision and strategy

- The service had a vision for what it wanted to achieve which it developed with staff and patients.
- The service had a clear vision. This was to ensure patients received a high quality, timely and effective service, to ensure the environment is safe and maintained, to ensure patients receive privacy, courtesy in comfortable surroundings, to ensure an open, honest, trustworthy approach. However, the service did not have strategy to show how the vision would be developed to turn the plans into action. There was no operational plan to underpin the vision and values.
- The service had a statement of purpose which outlined to patients the standards of care and support services it would provide.
- The core values of the service included promoting a culture of good and effective communication, to ensure safety and comfort for patients and to conduct financial and business arrangements with transparency.

Culture

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Staff described the culture of the centre as open and transparent where staff supported each other.
- Staff we spoke with were proud of the work that they carried out. They enjoyed working at the service; they were enthusiastic about the care and services they provided for patients. Staff described the service as a good place to work. Some of the staff we spoke with had worked for the provider for many years and were enthusiastic about the services offered and the care that was provided.

Governance

- The service did not have an effective system to improve service quality and safeguarded high standards of care.
- The service did not have an effective governance structure or framework. There were no clinical governance systems such as governance or risk meetings.
- The service had engaged a clinical governance consultant to reviews its procedures and formulate an action plan. The action plan was extensive with recommendations under safeguarding, training, staff meetings, appraisals, emergency medicines, fire safety and policies. We reviewed the action plan and found there were no clear lines of accountability and responsibility for actions to be taken.
- Policies and procedures were not reviewed regularly and updated where required. Records provided by the service show that the action plan was provided in April 2018. The service had updated two policies at the time of inspection.
- The service had obtained a generic set of policies and procedures from the clinical governance consultant. These had not been adapted to the requirements of the service.
- The service did not have regular staff meetings. We noted a management meeting was held it June 2018 which did not discuss the action plan and the governance issues that needed to be addressed. There was an administrative meeting in October 2018 to discuss improving support in the reception area.
- There was no evidence to show that learning was cascaded to staff. For example, updates, bulletins, or a newsletter.
- The service had completed an audit. However, there was not enough information on the outcomes or learning from the audit. Not all consultant reports were available within two days. However, the audit did not state the number of reports that were not completed within two days. The audit concluded that all action plans should be scanned in and all reports should be completed within two days. There was no action plan or timescale to address these issues or indication that a further audit would be repeated to assess improvement.

Diagnostic imaging

- The service had not undertaken infection control or hand hygiene audits.
- The service had a recruitment policy that set out the standards it followed when recruiting staff. The registered manager told us that, as part of the staff recruitment process, they carried out appropriate background checks. This included a full Disclosure and Barring Service (DBS), proof of identification, references check as well as driving license checks.
- We reviewed the staff files and found that these checks were not always completed. The service did not carry out DBS and identity checks for two clinical staff and references had not been obtained for five staff. The service did not have complete immunisation records showing immunity to Hepatitis B for three clinical staff. The service did not comply with its recruitment policy which stated these checks should be completed prior to employment.

Managing risks, issues and performance

- The service did not have effective systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service did not have a risk management strategy, setting out a system for continuous risk management. The service did not have a risk register. The risk of evacuating a patient from the basement in the event of a medical emergency had not been mitigated. The service had not undertaken a health and safety risk assessment.
- Where risks had been identified the service had not taken adequate steps to mitigate the risks. The service had completed a fire and Legionella risk assessment and there were action plans in place. There were no clear lines of accountability and responsibility for actions to be taken.
- Staff did not know about the incident reporting procedure and the requirements of the duty of candour.
- Safety alerts had not been reviewed and acted upon.
- The service had a business continuity plan that could operate in the event of an unexpected disruption to the service. This included the steps to be taken if there is potential disruption, such as fire or telecommunication system failure. The service had back-up generators which were regularly maintained and tested.

Managing information

- The service did not adequately collect, analyse, manage, and use information well to support all its activities, using secure electronic systems with security safeguards.
- The service did not have an up to date confidentiality and data protection policy. The policy had been updated in February 2013.
- There was no evidence staff had read or signed an information governance confidentiality statement or similar document to confirm that data security was understood.
- One staff member was using a generic log on to the clinical records system. This did not provide a clear audit trail by using a unique ID so that a 'footprint' of activity can be traced to an individual. This was a breach of information governance standards.
- Staff told us if errors in patient identifiable information occur for example, wrong date of birth, then these can be rectified by the cardiac physiologist on the system. This type of error was not considered to be an 'incident' and not raised or recorded as one. Information governance incidents were not being investigated.
- The service did not have clear oversight regarding patient consent form. The audit showed that 16% of the consent forms were shredded before they were scanned onto the patient's records.
- Staff had not completed training on information governance and the General Data Protection Regulation (GDPR).
- Staff had not received training on information governance (IG). The registered manager showed us new training matrix that would be implemented and this included training on IG.
- Staff told us procedures had been reviewed in response to GDPR such as encrypted emails and gaining authorisation to communicate with patients by email. There was no documented evidence of this review in the procedure.
- Electronic patient records could be accessed easily and were password protected.
- Staff reported no concerns about accessing relevant patient information. Staff had access to all the information they needed to deliver care and treatment to patients in an effective and timely way.
- Information from scans could be reviewed remotely by referrers to give timely advice and interpretation of results to determine appropriate patient care.

Inadequate

Diagnostic imaging

- The service was registered with the Information Commissioner's Office (ICO).

Engagement

- The service did not actively engage with patients, staff, the public and local organisations to plan and manage appropriate services.
- A patient satisfaction survey had not been completed since 2013. Staff told us the survey needed to be updated.
- The service received positive feedback from patients through letters and emails.
- There was limited evidence of staff engagement. There was one management meeting and an administrative meeting in the previous 12 months. Not all staff attended the meetings.

Learning, continuous improvement and innovation

- The service did not show commitment to improving services by learning from when things went well or wrong, promoting training and innovation.
- The service had not acted on the governance action plan it received in April 2018.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure there is a robust governance structure is implemented to improve patient safety, learn from patients' experience, and improve clinical effectiveness.
- Ensure there is an effective risk management system for monitoring and mitigating the various risks arising from the undertaking of the regulated activities.
- Ensure policies and procedures are reviewed regularly and a version control system is implemented.
- Ensure care and treatment is provided in a safe way to patients
- Ensure that an up to date record of training, skills and competence is kept for all staff members, particularly if they are responsible for providing care and treatment to patients.
- Ensure that appropriated recruitment checks are completed for all staff including appropriate checks through the Disclosure and Barring Service (DBS) proof of identity, references, and immunisation against Hepatitis B
- Ensure all staff are appropriately trained in safeguarding according to the requirements of the Intercollegiate Document.
- Ensure the safeguarding children and vulnerable adult's policy is updated to including a named safeguarding lead and relevant contact numbers to raise concerns.
- Ensure staff, including medical staff under practicing privileges, are supported in their roles by effective supervision and appraisal systems and ongoing training.

Action the provider SHOULD take to improve

- Ensure the protocol for medicines and equipment to manage a medical emergency is reviewed.
- Ensure infection control and hand hygiene audits are completed to make sure staff are compliant with infection control guidelines and policies.
- Ensure there is an effective system for recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Ensure there are arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued by the Medicines and Healthcare Products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England.
- Ensure there is a documented procedure for the Mental Capacity Act and best interest principles.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment must be provided in safe way for service users.** **We noted:** • Incidents were not formally investigated to ensure lessons were learnt and actions were taken to prevent future occurrence. • Not all staff had completed mandatory training. • Emergency medicines and equipment were not in line with guidance issued by the Resuscitation Council. • Safety alerts were not received and acted upon. • There was no evidence of immunisation against Hepatitis for two clinical staff. • The service did not have a cleaning schedule for the equipment and a spillage kit. **Regulation 12 (1)**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** **Service users must be protected from abuse and improper treatment in accordance with this regulation.** **Systems and processes must be established and operated effectively to prevent abuse of service users.** **We noted:**

This section is primarily information for the provider

Requirement notices

- There was no up to date safeguarding policy including a named lead, the relevant organisations to report to and their contact details.
- Not all staff had received safeguarding children and vulnerable adults training to an appropriate level.

Regulation 13 (1) (2)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** **Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.** **We noted:** • The service did not have an effective leadership structure including staff with the right skills and abilities to provide high-quality sustainable care. • There was no effective system to improve service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish. • Policies and procedures were not reviewed regularly and updated where required. • The service did not have regular staff meetings. • There were no clear lines of accountability and responsibility for completing the action plans from the governance audit, Legionella, and fire risk assessments • The service did not comply with its recruitment policy to ensure all checks were completed prior to employment • Audits such as infection control or hand hygiene had not been undertaken. • There was no risk management strategy, setting out a system for continuous risk management. • There was no effective system to improve services by learning from when things went well or wrong, promoting training and innovation.

This section is primarily information for the provider

Requirement notices

Regulation 17(1)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: 1. Persons employed for the purposes of carrying on a regulated activity must— a. be of good character, b. have the qualifications, competence, skills and experience which are necessary for the work to be performed by them, and c. be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed. 2. Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in— a. paragraph (1), or b. in a case to which regulation 5 applies, paragraph (3) of that regulation. 3. The following information must be available in relation to each such person employed— a. the information specified in Schedule 3, and b. such other information as is required under any enactment to be kept by the registered person in relation to such persons employed. We noted: • The provider did not undertake appropriate recruitment checks for all staff. Regulation 19(1)(2)(3)