Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Harley Street at UCH

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Date of Inspection: 28 October 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	HCA International Limited
Registered Manager	Ms. Sarah Fisher
Overview of the service	This service provides cancer, neurosurgical and general surgery services in a private patient centre, in partnership with University College Hospital NHS Trust in London. It is one of a number of locations operated by the provider. The hospital is based in central London.
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 28 October 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff and received feedback from people using comment cards.

What people told us and what we found

People felt involved in deciding the type of treatment that they had. They were happy with the service and felt that staff were caring and that they were "in safe hands." People said that they were treated with dignity and respect and that they were able to talk about their treatment. Some people did not speak or understand English and the provider had made provision for a team of interpreters to be available daily. People said that they felt safe and that they were well treated. Staff felt supported by the provider. They told us that their training was updated whenever new procedures were implemented. The provider had systems in place so that patients could comment on the service. The provider reviewed the service and changed the way it operated in response to people's comments or its own reviews of the service.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People who used the service were given appropriate information and support regarding their care or treatment. People told us that they were admitted to the hospital after a consultation with their doctor. They said that they were advised of their diagnosis and the treatment available. People told us that they had discussed other hospitals and treatments and that they had made an informed choice about where to attend and what treatment that they had. This was confirmed by records we saw, which included letters to people using the service advising them of the treatment, location, date and time and the fees. One person said, "Yes they gave me time to consider, but some treatments they have to do, it depends on the treatment. They always tell you what they are going to do and check that it is okay with you."

We saw that in each room there was a welcome pack providing information about the facilities. This included information regarding the different therapies provided, fees and the protection and use of patient information. There was guidance on making comments and complaints, including details of who to contact if people were unhappy about the service. Leaflets containing similar information were available in the reception and public areas of the hospital. People who use the service were given appropriate information and support regarding their care or treatment.

Three interpreters were available, working on a rota system, to support people for whom English was an additional language. We saw that one interpreter was translating information and noting information in the patient records. Staff told us that they always involved an interpreter as some relatives did not want the patient to know about their diagnosis and treatment in case it upset them. The Matron told us that interpreters were used to explain the hospital policy about consent and agreement about treatments as some people were from different cultures and not familiar with British laws.

We observed that most staff members knocked on people's doors before entering rooms. However, the provider may find it useful to note that some people told us that some staff

did not always knock.

After each hospital stay people were asked to complete a questionnaire about their experience. We were told that these were analysed by the provider's head office and that each Matrons responsible for each location received a monthly report. We were told that previous reports showed a need to improve on the catering and meal service. As a result the provider had begun to manage its own catering, rather than using the hospital's service. Recent questionnaires indicated that more improvements were needed. The Matron told us this was being addressed, by recruiting more staff, to allow more flexibility.

The questionnaire asked whether people had enough opportunity to speak to a doctor or a member of staff if they had concerns or worries. There were no concerns noted about the treatment people received from medical staff and other services. Each person had a named support worker, who they were able to contact if they wanted to discuss issues that did not relate to their medical treatment. Relatives were able to visit any time. One relative said that they were able to ask questions if they were concerned and that, "I feel very welcome, they are very friendly I never feel that I am intruding, I can come and go as I like."

Some people told us that the hospital's location was not convenient for them and arrangements had been made for some tests to be carried out nearer their home. One person said, "I prefer to be treated locally and insisted that small things like blood tests and dressings were done at another private hospital. But this one is the best place for my main treatments." People expressed their views and were involved in making decisions about their care and treatment.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

People who used the service said that they were satisfied with the care and treatment. However, some told us that the food was not always satisfactory as they did not always get what they had ordered. One person said and that on occasions they had to wait for staff to attend them or needed to remind staff of things for example, they said that they had new medication which was taken at a different time to usual. The provider was aware of people's dissatisfaction with the catering arrangements and was taking action to address the issue. One person who used the service said, "In general they are very good, they are all very good, professional and courteous."

We saw four care records and looked in detail at two for people who were happy to talk to us. All the care records had a care plan that was linked to the patient risk assessment. There were two types of admission plans, one for new patients that detailed the full medical and social history, and risks. The second type of plan focussed on the current medical needs. All plans and risk assessments were held electronically and recorded previous admission and treatment. The records could be accessed by all the nursing staff and doctors involved in the person's care. We saw that pre-admission checks were carried out on admission.

We were told and saw that all plans were reviewed weekly or more often if there was a change in the person's circumstances. People were aware that the provider held records on them. People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We observed that the staff shift handover was thorough, with discussion and written information being passed on so that staff were aware of any high risk alerts to patients. The staff told us that there was time allowed for them read people's medical notes at the beginning of the shifts. All high alerts were noted on a whiteboard as an extra reminder.

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a contract in place with the acute Trust Patient Emergency Response Team. The staff induction and training records confirmed staff were familiar with the critical call process. Emergency bags were available on each wing and we saw that there was a daily audit to check that these were in full working order. On the day that we visited there was

bad weather which prevented some staff attending. We saw that the Matron and other medical staff, who were carrying out other duties, covered for the absent staff. Staff members living more locally had been contacted and asked to undertake extra duties. We were told by the junior sister that she had delayed three admissions in consultation with senior staff until there was a full complement of staff. We were told that managers had authority to do this to ensure patient safety.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

We saw on the staff induction programme and on the records relating to training that all staff had to complete an E-Learning module on safeguarding vulnerable adults and child protection. We asked four staff about their understanding of safeguarding. Three staff were not familiar with the safeguarding adult's processes and not confident in their response when we asked how they would recognise different signs of abuse but said that if they were concerned about a person that they would refer the matter to their line manager. Staff were able to talk about patient safety when prompted. There was a corporate multi-agency local safeguarding policy based on the 2011 London- wide guidance, which advised staff of each stage of the safeguarding adults' process.

The Matron told us that there had been one safeguarding alert, which was some time ago. The hospital had worked with the local authority to protect the person. We noted that the provider was making plans for additional follow up training on all aspects of adult safeguarding including specific training on working with patients who lacked capacity. Managers spoke about actions that they would take to protect people if they thought that there was a need which included removing staff members and close monitoring.

People who used the service said that they felt very safe in the hospital. One person said, "Nothing untoward goes on here." People said that they felt they could trust the staff and did not feel the need to lock things away.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

The provider had worked to maintain and improve high standards of care by creating an environment where clinical excellence could do well. Staff told us that they felt supported by the provider and that there was a mentoring system in place. Each senior sister line managed junior sisters, who in turn were responsible for managing the nurses. Staff told us and we saw in their records that they received regular supervision and appraisals, which enabled them to identify any learning needs and to receive feedback on their performance. We saw that staff had been encouraged to develop their skills through attending training sessions.

There was a Clinical Facilitator who arranged for educational material about new techniques to be available to staff. For example staff told us about the additional training that they had in new transplant processes. We were told by the Matron that she arranged training after an assessment and analysis of staff appraisals and the supervision records.

An induction process was in place, so that new staff spent time reading the policies and procedures. They were then monitored by more experienced staff, as they worked as supernumerary to the staffing complement. As staff became familiar with the processes they had a meeting with their supervisor to agree when it was time to be on the rota. Staff said that they could have both informal conversations with colleagues and formal supervision. New members of staff attended the provider's general induction presentation, in addition to their clinical induction.

The provider acknowledged that the staff were required to discuss sensitive issues with people who used the service. As a consequence, the provider had made available a psychology service which people and staff could use confidentially. A member of staff said, "Within the team we try to support each other when a patient is not doing so well." There were regular ward meetings and we were told that if staff were unable to attend the minutes posted on the staff notice board. The six staff we spoke with from senior managers to health care assistants said that they received appropriate staff development. Staff members knew they could talk directly to their manager or the provider's head office if they had concerns. However, the provider may find it useful to note that staff were not familiar with the whistle blowing policy, which could have meant that staff were not able to

raise their concerns with the commission or other body for example the Nursing and Midwifery Council.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. We saw that the provider had made changes to the catering arrangements and was acting on people's further comments form to improve the service. Audits were undertaken monthly or more frequently on the management of medicines and other clinical audits, infection control measures and training. The findings were discussed at staff team meetings which were held monthly for all staff to receive and discuss information relating to the quality of the service. We saw that a report on the quality and safety of the service was discussed by consultants and the Clinical Director at quarterly Governance Meetings. We also saw that there was an external governance team which reviewed the findings from audits and recommended service improvements. We saw that there were no concerns raised from the last audit.

There was evidence that the provider learned from incidents and complaints and that appropriate changes were implemented. All incidents were noted in an electronic system which the Matron told us was reviewed and discussed with the ward sisters on a weekly basis and with staff in their staff meetings. The provider had changed the system of handovers at the end of shifts following an analysis and review.

The provider logged complaints and all staff had complaint training in their induction. People had complained about the food and this was being addressed by the installation of the new kitchen and recruiting more staff. One person had complained about the lack of choice on the television channels. We saw that the provider had negotiated a paid package with a commercial company who would be installing the service within the next month.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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