Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Infiniti Healthcare

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Infiniti Healthcare as part of its programme of assurance work. Infiniti Healthcare offers personalised gynaecology care for women including early pregnancy scans; general gynaecology services (including related aesthetic services); urogynaecology[1] (including related aesthetic services); and fertility services.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Care Standards Act 2000, Independent Health Care (Wales) Regulations 2011 and other relevant regulations. Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality Checks are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on four key areas; environment, delivery of safe and effective care, infection prevention and control and staffing. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the registered manager on 21 January 2021 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How are you ensuring that all patients (including vulnerable/at risk groups) are able to access services appropriately and safely? In your answer please refer to both the practice environment and processes to enable patients to access appointments
- What changes have you implemented in light of COVID-19 to ensure infection prevention and control standards are maintained?
- How has the clinic and the services it provides adapted during this period of COVID-19?

[1] Urogynecology or urogynaecology is a surgical sub-specialty of urology and gynecology.

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments and questioned the setting on the changes they have made in response to COVID-19 to maintain safety and patient dignity.

The following positive evidence was received:

The registered manager explained that during the early stages of the pandemic, the clinic closed for a period of four weeks in order to make changes to the environment to reduce the potential transmission of COVID-19. We were told that non-essential furniture and literature were removed from the waiting area with minimal seating remaining. The waiting area was no longer used by patients as only one patient was allowed in the clinic at any one time.

The way in which patients accessed the clinic had also changed. On arrival for their appointment, patients were asked to wait in their car or outside the clinic until it was clear to enter. When ready, the patient was escorted into the building, they were then required to sanitise their hands and apply a face mask before being taken directly to a consultation room. We were told that clinic appointments were spaced, to allow for social distancing.

The registered manager informed us that prior to COVID-19, all non-single use equipment was thoroughly cleaned and disinfected between patients. This had remained unchanged during the pandemic. Additional items were also added to the cleaning schedule. These included couches, chairs, desks, door handles and toilets being cleaned between each patient and this cleaning was all documented.

We were told that during the pandemic patients were prioritised according to how urgent their condition was. Urgent cases were seen first and patients with conditions that did not require urgent intervention were seen in due course. The amount of patients that were seen during a day was reduced in order to maintain patient and staff safety.

We reviewed how patients accessed appointments both digitally and over the phone. We were told that there was an online booking system for patients with digital access and a telephone booking system if required. Appointments were also arranged via General Practitioner (GP) referrals and conformation could be sent either electronically or on paper copies through the post. Patients without digital access could nominate a family member to receive digital information on their behalf. The registered manager told us that written confirmation was required from the patient to arrange this.

Since the onset of COVID-19, the registered manager told us that consultations could be undertaken online. This was carried out using the secure software HeyDoc[2] and a secure

[2] HeyDoc is a health communications software that allows secure online record keeping, online forms and

version of Zoom[3]. In order to confirm patients' identity the online video call could only be accessed when patients entered their date of birth.

We were told that the registered manager undertook risk assessments on staff members to determine their level of risk associated with contracting COVID-19. Systems were put in place to allow high risk staff to work from home. Two members of staff were required to shield under the initial guidelines. Laptops and secure software packages were purchased and both staff members were given equipment to allow them to securely work from home.

No improvements were identified.

Infection prevention and control (IPC)

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. We considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, cleaning and hygiene regimes and access to training.

The following positive evidence was received:

We saw evidence of an IPC policy which had been updated and reviewed recently. We were told that all patients were risk assessed for their vulnerability if they contracted COVID-19. This was done by sending an online link through HeyDoc which asked a series of questions with the answers from the patient determining whether they were considered a low, moderate or high risk of complications associated with contracting the virus. Patients were also required to complete another online link to determine their risk of having COVID-19.

We were told that personal protective equipment (PPE) had been purchased and that adequate stock was kept. The registered manager explained the checks that took place on arrival at the clinic, including patient temperature checks. The consultation would only proceed if the temperature check was within normal parameters[4].

The registered manager stated that he kept up to date with changes to government and Public Health Wales guidelines through email updates and communications with the health board. The registered manager stated that keeping up to date with guidelines had been difficult due to the frequency of updates. The IPC policy had been continuously used and was reviewed regularly. Updates from the NHS and HIW were used to change any guidance, for example the recent change to guidance relating to toilet hygiene that stated toilet facilities had to be cleaned and disinfected following each use.

video consultation for the purpose of non-urgent medical advisory.

[3] Zoom is a modern enterprise video communications software with a cloud platform for video and audio conferencing, chat, and webinars across mobile, desktop, and room systems.

[4] Normal body temperature ranges from 36.1 to 37.2 degrees Celsius.

We were told that COVID-19 specific training took place during the initial four week closure and updates were circulated verbally or by email. The COVID-19 training was in addition to the regular IPC training which included handwashing and use of PPE. We saw evidence that chaperone and cleaning schedules were maintained. Initially, virtual meetings were also held to develop an action plan for changes required in light of COVID-19.

We were told that there had been a planned closure of the clinic for three weeks from 23 December 2020 to 11 January 2021. During this time some staff members tested positive for COVID-19. This did not impact on clinic activity due to the planned closure, which occurs annually at that time.

No improvements were identified.

Governance / Staffing

As part of this standard, HIW explored whether management arrangements ensure that staff are suitable in their roles and are appropriately trained in order to provide safe and effective care. We reviewed recent risk assessments and questioned the setting on the changes they have made in response to COVID-19 to maintain safe practices.

The following positive evidence was received:

We saw evidence of staff training compliance, which included the training that had to be completed, the frequency and when this was last completed by staff.

In order to maintain adequate staff numbers, we were told that the service used staff from the healthcare clinic that they shared the building with. These staff members had employment checks including Disclosure and Barring Service[5] checks and the registered manager was shown evidence of this prior to them starting work at the service. We were told that agency nurses were not used.

The registered manager explained the process of checking emergency equipment and drugs. These were shared with the other clinic in the building and checks were carried out jointly between them, a minimum of once a month and prior to carrying out any medical or surgical procedure.

We explored the process of reporting incidents which were documented in an incident record book and reported to the relevant governing body. The registered manager informed us of one incident involving increased waiting time for a patient due to delayed phlebotomy results. This resulted in the patient appointment being delayed by several hours until results were obtained.

[5] A Disclosure and Barring Service (DBS) check is a process to find out whether someone has a criminal record.

The registered manager stated that staff wellbeing was monitored through informal discussions to ensure they felt safe and valued. The discussions gave staff the opportunity to express any issues they had both in and out of the workplace, such as work patterns and childcare issues. Any potential defects in existing processes, together with potential resolutions, were also explored during these discussions. This resulted in further purchases of laptops and secure IT systems, so non clinical staff could work from home.

No improvements were identified.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check.

As a result of the findings from this quality check, the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Improvement plan

Setting: Infiniti Healthcare

Ward/Department/Service (delete as appropriate):

Date of activity: 21 January 2021

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	No improvements were identified				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Name:

Date: