Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection - Announced

Parkway Clinic, Swansea

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Parkway Clinic on 10 March 2022. The focus of this inspection was on the oral surgery and ophthalmology services provided on the ground floor of the premises.

Our team for the inspection comprised of two HIW inspectors and two clinical peer reviewers.

HIW explored how the service complied with the Care Standards Act 2000, requirements of the Independent Health Care (Wales) Regulations 2011 and met the National Minimum Standards for Independent Health Care Services in Wales.

Further details about how we conduct independent service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Parkway Clinic provided safe and effective care in an environment that was welcoming and well-maintained.

Patients expressed high levels of satisfaction with the care and treatment received and we observed respectful interactions between staff and patients at all times.

We found evidence of overall good management and leadership at the hospital, which was underpinned by a range of policies and procedures

We identified a small number of improvements as identified below.

This is what we found the service did well:

- Patients expressed high levels of satisfaction with their experience
- Respectful interactions between staff and patients were observed
- Clear and cohesive treatment pathways
- Good decontamination practices and knowledge.

This is what we recommend the service could improve:

- Aspects of fire safety
- Aspects of quality improvement.

We identified a regulatory breach during this inspection. Further details can be found in Appendix B. HIW received timely and sufficient assurance that appropriate action had been taken immediately following the inspection.

3. What we found

Background of the service

Parkway Clinic is registered as an independent hospital at Lamberts Road, SA1 Waterfront, Swansea, SA1 8EL.

The service is registered to provide a range of general dentistry services, and consultant led services to include oral surgery, ophthalmology and cosmetic surgery treatments. Treatments under anaesthesia or sedation are available.

The staff team includes dental surgeons, oral surgeons, anaesthetists, nursing and theatre staff, management and administration staff.

Consultants are employed as independent medical practitioners on a sessional basis under practising privilege arrangements.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Patients expressed high levels of satisfaction with their experience at Parkway Clinic and we observed professional and respectful interactions between staff and patients at all times.

The hospital environment was modern and well maintained, providing patients with an overall welcoming experience.

During the inspection we distributed HIW questionnaires to patients to obtain their views on the services provided. A total of thirty were completed. Patients were asked in the questionnaire to rate their overall experience of the service. All thirty rated the service as 'very good'. Patients told us:

> *"Service was amazing, I believe there is absolutely no need for anything to change. Everything was spot on."*
>
> *"Overall, we are very happy with our visit today."*
>
> *"From the time we walked through the doors, to the time that we left, the service we received has been wonderful. Thanks."*

Health promotion, protection and improvement

We were told that due to COVID-19, reading material and information for patients to take away had been temporarily removed. However treatment specific leaflets were provided to patients as part of their assessment and patient guide leaflets were available to provide a general overview of services available at the hospital.

There were a number of posters and reminders related to COVID-19 safety. This included reminders to wear masks and to maintain good hand hygiene.

Dignity and respect

We observed staff interacting with patients in a respectful and professional manner at all times. All thirty questionnaire respondents told us that they had been treated with dignity and respect by the staff at the hospital.

The hospital environment was modern and visibly clean in all areas. Waiting areas were spacious and treatment areas were accessible to staff only.

All respondents told us that they were able to maintain their own privacy and dignity during their appointments and that they were able to speak to staff about their procedure or treatment without being overheard.

The recovery area was of an appropriate size for the number of beds and provided a suitable amount of privacy. For any children in receipt of treatment, we were told that parents are allowed to stay with them in the recovery area following their procedure.

Patient information and consent

A patient user guide was available which outlined the how the hospital operates, the referral process and the complaints procedure. A separate advice leaflet was available which outlined what patients must do before, during and following their appointment to ensure their safety. There were a small selection of individualised treatment specific leaflets to help provide patients with information relating to their procedure.

Treatment specific consent forms were used, which included any risks associated with the treatment and had been updated to reflect COVID-19 guidelines. We reviewed a sample of patient records and found that consent had been obtained in all cases.

All respondents told us that they felt involved as much as they wanted to be in any decisions made about their treatment and said that they had received enough information to understand what treatment options were available.

For fee paying patients, all respondents told us that the cost of treatment was made clear before they received treatment.

Communicating effectively

We observed staff talking to patients in a respectful and professional tone at all times during the inspection. This extended to clinical and non clinical staff.

Three patients told us that they were unable to communicate with staff in their preferred language, Welsh. Four patients told us that healthcare related information was not available in their preferred language. However the service told us that language line and a small number of Welsh speaking staff were

available. The service is advised to further consider how the hospital can proactively identify and meet the language needs of all patients.

Care planning and provision

The hospital provides treatment to NHS and private patients. Patients referred to the hospital from within the NHS are provided with relevant information to help them understand the proposed care and treatment. The referring medical practitioner is responsible for the initial assessment of patient to ensure their suitability for treatment. Private patients are assessed by the hospital directly.

Treatment specific care plans for adults and children were in use. These recorded a breadth of patient details, including medical histories. For children, specific details were recorded relating to the child's understanding of the procedure and how any anxieties associated with receiving treatment had been relieved.

Relevant discharge and post-operative care information was provided to patients. We saw examples of discharge letters, which we confirmed were returned to the referring practitioner in a timely manner.

All 30 respondents told us that they completed a medical history form or had their medical history checked before undertaking any treatment and had been given information on how to care for themselves following their treatment.

Equality, diversity and human rights

We found that patients could attend the hospital with a chaperone if they required additional support in accessing the service. There was a clear policy in place that patients had to be accompanied following certain procedures, such as general anaesthetic, to ensure their safety.

Staff we spoke with were generally aware of the Deprivation of Liberty Safeguards (DoLS) and how to provide care to patients who may lack mental capacity. We also confirmed that DoLS training had been provided to staff.

We advised the service to give further consideration to the signage in the overall environment, particularly for certain patient groups and those receiving ophthalmic treatments, and the purchase of a hearing loop to ensure that the service remains fully accessible to all.

Citizen engagement and feedback

Patients who completed a HIW questionnaire provided overwhelmingly positive feedback relating to their experience at the service.

We found that there were appropriate systems in place to obtain, review and respond to patient feedback and complaints. This included patient satisfaction surveys provided to patients following their treatment. Results of these surveys were on display in public view.

Posters and feedback leaflets were also available throughout the hospital and this included details on the formal complaints process if required. Details of external organisations, including HIW, were listed in this literature in order to provide an additional source of support.

We found that there had been a low number of complaints. We reviewed a sample of these and found that they had been acknowledged and responded to in an appropriate timeframe.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Overall we found that staff provided safe and effective care to patients. This was underpinned by a breadth of suitable processes and procedures to ensure that a good level of care was maintained.

There were good decontamination processes in place and staff demonstrated a strong technical knowledge.

A small number of improvements were identified in order to strengthen existing practice at the service.

Managing risk and health and safety

Overall, we found suitable arrangements were in place to protect the safety and wellbeing of staff and visitors to the practice. The hospital had a range of localised policies and procedures in place to ensure the premises were safe and fit for purpose.

As a result of changes due to the pandemic, we were told that patients are screened for COVID-19 symptoms prior to their appointment. Self-isolation was required for certain treatments and we confirmed that staff checked that this was adhered too before treatment was provided. We confirmed that air changes related to aerosol-generating procedures had been reviewed in line with UK public health guidelines.

The building was of a modern build and appeared to be well maintained internally and externally. The clinical and public areas of the hospital were spacious and provided ground floor access to patients and in the event of a medical emergency.

A recent fire risk assessment had been completed and we were verbally told what actions had been taken, but we found that these were not documented in the risk assessment action plan.

Improvement needed

The service must document actions that have been taken and when, according to the level of risk identified in the fire risk assessment action plan.

Infection prevention and control (IPC) and decontamination

All areas of the hospital were visibly clean and in a good state of repair. Cleaning was completed by an external contractor and cleaning schedules were completed. All cleaning materials were stored securely.

The decontamination lead roles were held jointly by two of the nursing staff. They demonstrated a strong knowledge of their roles, responsibilities and procedures that are to be followed.

Hand hygiene facilities were adequate and staff were observed using personal protective equipment (PPE) appropriately. Appropriate measures were implemented in response to the pandemic, including face fit testing[1] of staff.

There was an appropriate protocol for dealing with sharps injuries. We noted that a re-sheathing device was in use and that vaccination records were kept in staff files.

There were appropriate processes in place to ensure that reusable instruments were decontaminated. This involved disinfection within the hospital using equipment which had been tested according to WHTM 01-05[2] requirements. External contractors were used to collect and return instruments used in other surgical procedures.

[1] A test which checks whether a person's PPE mask fits their face shape and size.

[2] Welsh Health Technical Memorandum (WHTM) 01-05 is intended to raise the quality of decontamination work in primary care dental services by covering the decontamination of reusable instruments.

We reviewed a sample of staff files and found that infection control training had been completed and that staff were working towards the required number of hours as required by their professional body.

Without exception, patients who completed a questionnaire rated the service as ‘very clean’ and all but one told us that ‘COVID-compliant’ procedures were ‘very evident’ during their time at the service.

Medicines management

There was a medication management policy and procedure in place and we found medication storage to be generally good in all areas.

However, we identified an issue relating to the storage of temperature sensitive medication. This was due to a domestic fridge being used to store some medication and we could not be assured of its suitability to store medicinal products. We found that medication was otherwise stored appropriately and securely in other areas of the hospital.

We found that daily fridge temperature checks were generally documented on a consistent basis, but we found that that there were gaps in the theatre fridge log where checks hadn’t been completed and documented.

Due to the timely nature of this concern, we dealt with this matter through the HIW non-compliance process. We received sufficient assurance from the service that this had been rectified by the time of publishing this report. Details of the action taken can be seen in Appendix B.

Safeguarding children and safeguarding vulnerable adults

The service had an appropriate policy and procedure in place to follow in the event of any safeguarding concerns relating to potentially vulnerable adults or children.

There was a designated safeguarding lead for the hospital and we confirmed that training had been completed to an appropriate level.

Medical devices, equipment and diagnostic systems

The service had a range of medical devices, equipment and systems which appeared to meet the care and treatment needs of patients.

We found that there were suitable processes in place for regular maintenance and for the reporting of any issues. This included service maintenance agreements and the appointment of a laser protection advisor.

Safe and clinically effective care

We found that there were cohesive treatment and care pathways in use at the service, which enabled patients to receive treatment in a timely manner. There were suitable pre-operative and post-operative procedures in place for the treatments provided.

We considered how conscious sedation and general anaesthetic procedures were carried out in a safe and effective manner. We found:

- The surgery and recovery areas were of an adequate size to provide treatment and for the management of emergencies
- Suitably qualified clinical staff were employed and staff were trained to at least intermediate life support (ILS) level
- Relevant emergency drugs and equipment were readily available and in date
- Equipment, including the general anaesthesia machine, and medical gases had appropriate service maintenance contracts.

We noted that conscious sedation was not being routinely provided at the time of the inspection.

We considered how the ophthalmic laser equipment and associated documentation had been maintained to ensure that safe and effective care is provided. We found:

- Treatment protocols and recently reviewed local rules were in place and staff were suitably qualified to carry out the designated treatments
- Laser equipment was under a service maintenance contract
- A Laser Protection Advisor (LPA) was appointed and a recent robust audit had been completed with no significant findings

- Core of Knowledge[3] training had been completed in the sample of laser operator files that we reviewed.

We confirmed that emergency drugs and emergency resuscitation equipment was available and met the Resuscitation Council (UK) standards for the treatment of adults and children. Regular checks of this kit had been completed and logged appropriately.

Participating in quality improvement activities

The hospital had mechanisms in place to gain patient feedback and there was evidence that feedback was reviewed and, where appropriate, acted upon.

We found that there was some audit activities carried out, including infection control and radiography quality audits. However, we would recommend that the hospital considers expanding its quality improvement programme as the services and treatments it provides develops and increases. Particular emphasis should be placed on clinical outcomes, e.g. National Cataract Audit.

Improvement needed

The service should explore how it can expand its quality improvement activities.

Records management

Patient records relating to oral surgical procedures were stored on an electronic system, which appeared to be secure with restricted access. Ophthalmic patient records were paper based and stored in a locked cabinet.

Overall, we found a very good standard of record keeping. Patient notes were contemporaneous and surgical safety checklists were in use. However, we found that some ophthalmology records lacked signatures or countersignatures by the relevant consultant where required.

[3] Core of Knowledge certification required by the Medical and Healthcare Products Regulatory Agency (MHRA)

Improvement needed

The service must ensure that all patient documentation is signed and countersigned as required.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Independent Health Care Regulations and National Minimum Standards.

Overall we found good management and leadership from an established team within the hospital and staff teams appeared to work well together.

Staff training needs had continued to be met throughout the pandemic and appraisals had been completed to ensure that staff performance, learning and development needs are continually reviewed.

Governance and accountability framework

We found an established management team who demonstrated a strong commitment towards providing patients with a positive experience and safe care. Management were complementary of their staff teams, including the way in which all staff had responded to the pandemic.

There were clear lines of management and accountability through management and staff teams. Staff we spoke with were clear in how they conducted their roles and were aware of their responsibilities towards patients and other colleagues.

There was an appropriate flow of information between the weekly senior team meeting, monthly staff meeting and daily team huddle.

Dealing with concerns and managing incidents

The service had a low number of complaints and one incident recorded. We reviewed the incident and found that all steps had been undertaken to appropriately respond to, investigate and report the incident to HIW. No further actions were required relating to this incident.

Workforce planning, training and organisational development

We reviewed a sample of staff files and found comprehensive records of training. However the service is advised to consider use of a training matrix to easily log

and identify any outstanding training needs with ease. The registered manager told us that additional training needs are considered on a case by case basis and that staff can discuss their development needs through an annual appraisal process. Staff we spoke with confirmed that they had undertaken an appraisal within the last twelve months.

We found that efforts had been made to ensure that staff were able to complete online training during the pandemic and that face to face training would be resumed as soon as possible.

We noted that there were a low number of vacancies at the time of the inspection, but were told that active efforts were underway to recruit into these positions.

We reviewed a sample of staff rotas and found that there was a sufficient number of staff to meet patient needs. Staff told us that theatre lists and appointments are scheduled in advance which helps to plan appropriate staffing arrangements.

Workforce recruitment and employment practices

We reviewed a sample of staff files and found that all staff had undergone appropriate pre-employment checks. This included conducting interviews, obtaining references, and completion of disclosure and barring service (DBS) checks to help to ensure the suitability of staff. We confirmed that clinical staff were registered with their relevant professional body.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non-compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- 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.

As a result of the findings from this inspection 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.

5. How we inspect independent services

Our inspections of independent services may be announced or unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection. In some circumstances, we will decide to undertake an announced inspection, meaning that the service will be given up to 12 weeks' notice of the inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of independent healthcare services will look at how services:

- Comply with the Care Standards Act 2000
- Comply with the Independent Health Care (Wales) Regulations 2011
- Meet the National Minimum Standards for Independent Health Care Services in Wales.

We also consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within independent services.

Further detail about how HIW inspects independent services can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
-	-	-	-

Appendix B – Immediate Improvement plan

Service: Parkway Clinic

Date of Inspection: 10 March 2022

Description of non compliance / Action to be taken	Regulation	Service Action	Responsible officer	Timescale
The setting must ensure that: 1. Medication is stored in an appropriate fridge 2. Daily fridge temperature checks are completed at all times.	Regulation 15(5)(a)	A new medical fridge Coolmed CMS300, with Calibration, keyless combination lock, and a data logger was ordered, the same day as the inspection. Due to arrive during next few days In the meantime the fridge in situ is checked and logged every day. There was only 5 days unlogged within the last 18 months.	P & S Majoe	Immediate on both parts Immediately

Appendix C – Improvement plan

Service: Parkway Clinic

Date of inspection: 10 March 2022

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The service must document actions that have been taken and when according to the level of risk in the fire risk assessment action plan.	Regulation 26(4)	The fire risk assessment paperwork is now completed	S Majoe	Immediate
The service should explore how it can expand its quality improvement activities.	Regulation 19	The Eye surgeons are currently looking into new areas of quality improvement.	L Anderson	Ongoing
The service must ensure that all patient documentation is signed and countersigned as required.	Regulation 23	An email has been sent to all surgeons reminding them of the importance of signatures on all appropriate paperwork.	S Majoe	Immediate

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.

Service representative

Name (print): S Majoe

Job role: Registered Manager

Date: 26/4/2022