



# RQIA Provider Guidance 2020-2021

## Independent Health Care

### Independent Hospital

[www.rqia.org.uk](http://www.rqia.org.uk)

# What We Do

The Regulation and Quality Improvement Authority (RQIA) is the independent body that regulates and inspects the quality and availability of Northern Ireland's health and social care (HSC) services. We were established in 2005 under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to drive improvements for everyone using health and social care services.

Through our programme of work we provide assurance about the quality of care; challenge poor practice; promote improvement; safeguard the rights of service users; and inform the public through the publication of our reports. RQIA has four main areas of work:

- we register and inspect a wide range of independent and statutory health and social care services;
- we work to assure the quality of services provided by the HSC Board, HSC trusts and agencies - through our programme of reviews;
- we undertake a range of responsibilities for people with mental ill health and those with a learning disability; and
- we support establishments and service providers to improve the service they deliver.

All work undertaken by RQIA is focused on the following four domains:

- is care safe?;
- is care effective?;
- is care compassionate?; and
- is the service well led?.

RQIA registers, and inspects and supports a wide range of health and social care services. These include: nursing, residential care, and children's homes; domiciliary care agencies; day care settings/centres; independent health care; nursing agencies; independent medical agencies; residential family centres; adult placement agencies; voluntary adoption agencies, school boarding departments and young adult supported accommodation (inspected only).

# The Four Domains



# How We Will Inspect

We will inspect every independent hospital at least annually. Our inspectors are most likely to carry out an announced inspection, however from time to time we may carry out an unannounced inspection in response to concerns that may be raised with us.

When we inspect an independent hospital, we aim to provide assurances in respect of the standard, quality and safety of services delivered. We do this by:

- seeking the views of the people who use the service, or their representatives;
- talking to the management and other staff on the day of the inspection;
- examining a range of records including care records, incidents, complaints and policies;
- providing feedback on the day of the inspection to the registered person/manager on the outcome of the inspection; and
- providing a report of our inspection findings and outline any areas for quality improvement.

Our inspections are underpinned by:

- [The Health and Personal Social Services \(Quality, Improvement and Regulation\) \(Northern Ireland\) Order 2003](#)
- [The Independent Health Care Regulations \(Northern Ireland\) 2005](#)
- [The Regulation and Improvement Authority \(Independent Health Care\) \(Fees and Frequency of Inspections\) \(Amendment\) Regulations \(Northern Ireland\) 2011](#)
- [The Department of Health \(DOH\) Minimum Care Standards for Healthcare Establishments July 2014](#)

Provider guidance in respect of the maintenance and upkeep of the premises and the management of medicines are also available on our website [here](#). These documents should be reviewed to ensure compliance with the minimum standards and legislation.

Should you have additional categories of care, please ensure that you review and adhere to the relevant provider guidance document i.e. Private Doctor (PD).

# What We Look For When We Inspect

To help us to report on whether the care is safe, effective and compassionate and whether the service is well led, we will look for evidence against the following indicators.

## Is care safe?

**Avoiding and preventing harm to service users from the care, treatment and support that is intended to help them.**

### Indicator S1

There are, at all times, suitably qualified, competent and experienced persons working in the service in such numbers as are appropriate for the health and welfare of service users.

### Examples of Evidence

#### Staffing

- there are arrangements in place to provide cover at all times by appropriately trained and experienced medical and health care practitioners;
- the staffing complement meets the assessed care needs of all patients, taking into account the size and layout of the hospital, the statement of purpose and fire safety requirements;
- there is a defined staffing structure for surgical services that defines lines of accountability, specifies roles and details responsibilities for areas of activity;
- there are sufficient numbers of staff in various roles to fulfil the needs of the hospital and patients;
- there is an induction programme in place appropriate to the role;
- a system is in place to ensure staff receive annual appraisal, records should be retained;
- a system is in place to ensure all staff receive appropriate training to fulfil the duties of their role including professional body Continuing Professional Development (CPD) and [RQIA training guidance](#);
- a system is in place to ensure that staff receive mandatory training and appropriate training when new procedures are introduced, records should be retained for inspection;
- there are arrangements for monitoring the professional registration status with the regulatory body (e.g. GMC, NMC, HCPC) of all clinical staff, records should be retained for inspection;
- there are arrangements in place for monitoring the professional indemnity for the service and of all staff who require individual indemnity cover, records should be retained for inspection;
- evidence that each private doctor has confirmation of identity, current General Medical Council (GMC) registration, professional indemnity insurance, qualifications in line with service provided; evidence of ongoing professional development and continued medical education that meets the requirements of the Royal Colleges and GMC;
- evidence that each private doctor has an appointed responsible officer (RO);
- arrangements are in place to link into the wider system of RO's for doctors with practising privileges who work in other parts of the NI healthcare system or in other healthcare systems beyond NI;
- evidence of arrangements for revalidation; and
- the private doctor is aware of their responsibilities under GMC [Good Medical Practice](#).

#### Recruitment and Selection

- staff have been recruited in line with Regulation 19 (2), Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended;
- there is a written policy and procedure for staff recruitment in keeping with Regulation 19 (2) Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005;
- staff personnel files are in keeping with 19 (2) Schedule 2, as amended;

- enhanced AccessNI checks received prior to new staff commencing work;
- recruitment and selection records should be retained in keeping with Regulation 21 (3) Schedule 3 Part II; and
- an up-to-date staff register should be maintained and retained in keeping with Regulation 21 (3) Schedule 3 Part II.

### Indicator S2

The service promotes and makes proper provision for the welfare, care and protection of service users.

### Examples of Evidence

#### Surgery

- the policies and procedures for surgical services are in accordance with best practice guidelines as defined by professional bodies and national standard setting organisations including the World Health Organisation (WHO) Surgical Checklist and Surgical Pause;
- all surgical patients are assessed to identify the risk of venous thromboembolism (VTE) and bleeding in keeping with NICE guideline [NG89];
- a fluid management policy in keeping with [HSC \(SQSD\) \(NICE CG174\) 17/14](#) and [NICE Clinical Guidance CG174](#) is in place and audited to provide assurance that the policy is being adhered to;
- an anti-microbial/antibiotic stewardship policy in keeping with NICE guideline [NG15] is in place and audited to provide assurance that the policy is being adhered to;
- an appropriate register of all surgical operations performed in the hospital is kept in accordance with the Independent Health Care Regulations (Northern Ireland) 2005;
- a senior registered nurse or operating department practitioner who has operating theatre experience is in charge at all times in the operating theatre;
- scheduling of patients for surgical procedures takes into account patients' requirements, staffing levels, nature of surgical procedure, facilities and equipment available. Any associated risks are managed;
- the anaesthetist is present in the operating theatre throughout the operation and is present on-site until the patient has recovered from the immediate effects of anaesthesia;
- the anaesthetist who is to give the anaesthetic visits the patient, assesses the general medical fitness, and reviews any medication being taken prior to surgery. Possible plans of management are discussed with the patient and available options are explained, to enable the patient to make an informed choice;
- patients are observed during surgery and in the recovery room on a one-to-one basis by staff trained in anaesthetics and resuscitation;
- the anaesthetist who administered the anaesthesia discharges patients in accordance with recovery room procedures; and
- all patients admitted for elective surgery have a preoperative assessment in keeping with [NICE guideline \[NG45\]](#).

#### Safeguarding

##### Adult

- policies and procedures are in line with the regional [Adult Safeguarding Prevention and Protection in Partnership policy \(July 2015\)](#) and Adult Safeguarding Operational Procedures (2016);
- the practice has identified an adult safeguarding champion (if required);
- there is an identified safeguarding lead in the practice and staff are aware of who the safeguarding lead is;
- there are arrangements in place to embed the regional adult safeguarding operational

procedures;

- all staff receive the relevant level of training as outlined in [RQIA training guidance](#);
- staff training should be in keeping with the [Northern Ireland Adult Safeguarding Partnership \(NIASP\) Training Framework \(revised June 2016\)](#);
- staff are knowledgeable about adult safeguarding and are aware of their obligations in relation to raising concerns;
- all suspected, alleged or actual incidents of abuse are fully and promptly referred to the relevant persons and agencies for investigation in accordance with procedures and legislation; written records must be retained;
- where shortcomings are highlighted as a result of an investigation, learning arising should be assessed, implemented and quality assured; and
- staff are familiar with their responsibilities and know how to appropriately recognise poor practice and raise concerns.

### **Children**

- policies and procedures are in line with the regional [Co-operating to Safeguard Children and Young People in Northern Ireland. \(August 2017\)](#) and [Safeguarding Board for Northern Ireland \(SBNI\) Procedures Manual \(November 2017\)](#);
- there is an identified safeguarding lead in the practice and staff are aware of who the safeguarding lead is;
- there are arrangements in place to embed the regional procedures manual;
- all staff receive the relevant level of training as outlined in [RQIA training guidance](#);
- staff training should be in keeping with [SBNI Child Safeguarding Learning and Development Strategy and Framework 2015 – 2018](#);
- staff are knowledgeable about safeguarding children and are aware of their obligations in relation to raising concerns;
- all suspected, alleged or actual incidents of abuse are fully and promptly referred to the relevant persons and agencies for investigation in accordance with procedures and legislation; written records must be retained;
- where shortcomings are highlighted as a result of an investigation, learning arising should be assessed, implemented and quality assured; and
- staff are familiar with their responsibilities and know how to appropriately recognise poor practice and raise concerns.

### **Indicator S3**

There are systems in place to ensure that unnecessary risks to the health, welfare or safety of service users are identified, managed and where possible eliminated.

### **Examples of Evidence**

#### **Best Practice Guidance**

- the hospital has a procedure in place to review newly published best practice guidance and develop and implement policies and procedures as necessary; and
- the hospital has a policy for the identification and labelling of invasive lines and tubes in line with the regional guidance.

#### **Risk Management**

- there are risk management procedures in place;
- all risks in connection with the hospital, treatment and services are identified, assessed and managed;
- arrangements are in place to provide evidence of appropriate review of risk assessments. Any

- findings/learning arising from risk assessments should be implemented and assured; and
- an overarching corporate risk register is in place which details the measures in place to mitigate and control identified risks.

### **Resuscitation**

- a policy in relation to the management of resuscitation and medical emergencies is in place (to include training arrangements, provision of equipment, emergency medication, checking procedures, how to summon help, incident documentation and staff debriefing);
- staff have received basic life support training, records of training should be retained;
- staff have knowledge and understanding of managing resuscitation and medical emergencies;
- there is at least one person with advanced life support training (ALS) on duty at all times. Staff providing medical cover are trained in resuscitation to the appropriate level. This training is updated in line with RQIA mandatory training and includes paediatric advanced life support training;
- equipment for resuscitating patients is in line with the Resuscitation Council (UK);
- resuscitation equipment is checked and restocked to ensure all equipment remains in working order and suitable for use at all times. Checks are carried out daily by a designated person and recorded;
- resuscitation equipment is cleaned and decontaminated after each use;
- all 'do not resuscitate decisions' are documented by the most senior health care professional caring for the patient, with the reason and date for review documented in the patient's clinical record. This information is provided to other relevant health professionals and is reviewed and documented by the planned review date or when there are any significant changes in the patient's condition; and
- medicines required for resuscitation or other medical emergencies are clearly defined and are regularly monitored. These medicines are readily accessible in suitable packaging and available for use at all times. Accessible records are maintained relating to the regular monitoring of medicines required for resuscitation or other medical emergencies.

### **Infection Prevention Control and Decontamination Procedures**

- the hospital is clean and clutter free;
- infection prevention and control (IPC) policies and procedures are in place in keeping with [The Northern Ireland Regional Infection Prevention and Control Manual](#);
- all staff receive training in infection prevention and control that is commensurate with their role and responsibilities, records should be retained;
- arrangements are in place to deliver Aseptic Non Touch technique (ANTT) training to appropriate staff. Staff who have completed ANTT training are competency assessed and a rolling audit programme is in place to provide assurance that staff are adhering to best practice following training;
- staff have knowledge of infection prevention and control measures in line with best practice;
- there are written guidelines for staff on making referrals for advice and support to infection control nurses, microbiology services and public health medical staff who have expertise in infection prevention and control;
- the risk of cross infection to patients, staff and visitors is minimised by single use equipment or decontamination of reusable medical devices and equipment in line with manufacturer's instructions and current best practice;
- there is information available for infection prevention and control for patients, their representatives and staff;
- there is an annual infection control programme of audits in place;
- there are clear lines of accountability in relation to IPC and staff are aware of their roles and responsibilities; and
- exploration of any issues identified during inspection.

## **COVID-19**

COVID-19 policies and procedures are in place in adherence to best practice guidance and should outline the management of operations in response to COVID-19 to include the following arrangements;

- establishment preparation;
- staff preparation;
- patient pathway;
- standard and enhanced infection prevention and control procedures; and
- clinical prioritisation.

Arrangements are in place to routinely review the websites listed below:

- Public Health Agency (PHA) COVID-19 webpage: <https://www.publichealth.hscni.net/covid-19-coronavirus>;
- Northern Ireland (NI) direct COVID-19 webpage: <https://www.nidirect.gov.uk/campaigns/coronavirus-covid-19>; and
- Public Health England (PHE) advice for health professionals: <https://www.gov.uk/government/collections/wuhan-novel-coronavirus>.

## **Indicator S4**

The premises and grounds are safe, well maintained and suitable for their stated purpose.

### **Examples of Evidence**

#### **Environment**

- the hospital is clean, clutter free, warm and pleasant;
- there are no obvious hazards to the health and safety of patients and staff;
- there are arrangements in place in relation to maintaining the environment (e.g. servicing of lift/gas/boiler/fire detection systems and fire-fighting equipment, fixed electrical wiring installation, legionella risk assessment);
- arrangements are in place to ensure that environmental risk assessments are reviewed on an annual basis. Any findings/learning arising from risk assessments should be implemented and assured;
- equipment, installations and facilities are in place to provide services in accordance with the statement of purpose and are used, serviced and maintained in line with DOH requirements and manufacturers' and installers' guidance; and
- there is register of all mechanical and technical equipment used for the purposes of treatment provided by the hospital.

# Is care effective?

The right care, at the right time in the right place with the best outcome.

## Indicator E1

The service responds appropriately to and meets the assessed needs of the people who use the service.

## Examples of Evidence

### Nutrition and hydration

- protected meal times are adhered to by staff;
- menu choice/beverages/snacks are available to include specialised dietary requirements and smaller portion sizes as appropriate;
- a designated person is responsible to supervise and co-ordinate the service of meals;
- staff prepare the patient for mealtimes (toileting, positioning in chair/bed, remove obstacles from the bedside tables, hand hygiene);
- effective mechanisms are in place to identify patients that require assistance at mealtimes (red trays or other system to identify patients who require assistance are in use);
- there are sufficient staff allocated to support and supervise those who need assistance;
- food is appropriately placed in front of patients and assistance given with any food which requires opening/cutting. Assistance with eating is given in an appropriate manner (timely/staff not standing over patients);
- patients have a drink\* available and accessible at the bedside (fresh water is available for all patients, water in reach of patients, frequency of assistance to offer and encourage patients to drink);
- appropriate tableware is available for all patients including those with reduced dexterity (crockery, cutlery, drinking cups);
- all staff participate in the collection of food trays after meal service to accurately identify/report patients' intake at mealtimes;
- where a meal is interrupted or missed a replacement meal can be accessed;
- where a decision to fast is made, there is evidence in the record of a review and alternative means of hydration considered;
- the regional fluid balance chart is used appropriately and completed effectively;
- food charts are used appropriately and completed effectively;
- nutritional supplements are prescribed and administered appropriately (not at mealtimes/as a substitute for meals);
- nutritional supplements are offered to adults at risk of, or who have pressure ulcers, or who have a nutritional deficiency; and
- resources to support safer modification of food and drink to include the implementation of standard terminology to describe texture modification for food and drink in keeping with the [International Dysphagia Diet Standardisation Initiative \(IDDSI\)](#) framework has been implemented.

### Care Pathway

- on admission patients have a comprehensive assessment of their health care needs using evidence based assessment tools;
- the results of assessments are used to draw up an individualised person-centred care plan which reflects pre-operative, intra-operative and post-operative care. Where possible the care plan is shared and signed by the patient;
- all treatment and care is recorded in the patient's clinical record;
- there are arrangements in place to meet the patient's assessed needs - including, if necessary, referral to specialised services;
- there are arrangements for pre-operative, intra-operative and post-operative care in line with the patients' assessed needs;

- arrangements are in place to enable relevant professionals to contribute to the multidisciplinary review of outcomes of patient care;
- there is a planned programme for discharge from the hospital for each patient; and
- the discharge plan is co-ordinated with the services involved in the patient's ongoing care and treatment.

### Records

- arrangements are in place for maintaining and updating clinical records;
- record keeping is in accordance with legislation, standards and best practice guidance; [GMGR records management](#);
- a policy and procedure is available which includes the creation, storage, recording, retention and disposal of records;
- records are securely stored – electronic/hard copy;
- the hospital is registered with the Information Commissioners Office (ICO);
- there are systems in place to audit the completion of clinical records and an action plan is developed to address any identified issues;
- staff display a good knowledge of effective records management;
- the establishment has arrangements in place to comply with the [General Data Protection Regulation \(GDPR\)](#) legislation which was effective from May 2018; and
- a patient register in keeping with Schedule 3 Part II of the Independent Health Care Regulations (Northern Ireland) 2005 is maintained and kept-up to date.

### Indicator E2

There are arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to service users at appropriate intervals.

### Examples of Evidence

- a range of audits, including clinical audits, are undertaken routinely and actions identified for improvement are implemented into practice;
- the medical advisory committee and other key governance committees reviews and comments on the audit of core key quality indicators;
- arrangements are in place to escalate shortfalls identified during the audit process through the hospitals governance structures; and
- there are clear clinical governance arrangements in place to ensure the effectiveness and quality of care to patients and their representatives.

### Indicator E3

There are robust systems in place to promote effective communication between service users, staff and other key stakeholders.

### Examples of Evidence

#### Informed Decision Making

- patients receive all the necessary information about their admission and treatment. This is available in an alternative language or format when required;
- patients receive an explanation of the clinical assessments, which will be carried out by different members of the health care team. This is communicated in a language and manner which is appropriate to the patient's age and understanding;
- patients receive verbal and written pre-operative information. There is written information for

patients that provides a clear explanation of any treatment provided and includes effects, side-effects, risks, complications and expected outcomes. This information is in a format which is accessible according to the patient's age and level of understanding and must be provided in alternative formats if necessary;

- the surgeon/practitioner who is to undertake the surgical procedure visits the patient and obtains consent for the proposed surgery and ensures the consent form(s) are signed prior to surgery;
- there is written information for patients post-operatively;
- the results of investigations and treatment are clearly explained to patients and any options available to them are discussed;
- a named member of staff is identified as the principle contact for each patient;
- the care plan is reviewed with the patient and or their representative in keeping with their changing needs;
- the patient and their representative are kept informed about any changes in the patient's condition;
- information is written which is jargon free, accurate, accessible and up-to-date;
- treatment and care services are planned and developed with meaningful patient involvement; facilitated and supported as appropriate; and provided in a flexible manner to meet individual and changing requirements;
- there are meaningful detailed handover reports;
- there is an open and transparent culture that facilitates the sharing of information;
- staff meetings are held on a regular basis and minutes retained;
- staff can communicate effectively; and
- learning from complaints/incidents/near misses is effectively disseminated to staff , implemented and assured.

#### **Discharge Planning**

- the planned programme for discharge from the hospital provides the patient and carers with clear, accessible written information on:
  - the discharge arrangements;
  - future management of care;
  - liaison with community services;
  - advice and support available; and
- where appropriate to the setting and in line with the patient's wishes, a discharge letter summarising the patient's treatment and care is sent to their general practitioner and other professionals involved in their ongoing treatment and care.

# Is care compassionate?

**Service users are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.**

## Indicator C1

There is a culture/ethos that supports the values of dignity and respect, independence, rights, equality and diversity, choice and consent of service users.

### Examples of Evidence

- staff can demonstrate how confidentiality is maintained;
- staff can demonstrate how consent is obtained;
- there is a written policy and procedure on obtaining informed consent in line with [DOH guidance on consent treatment and care](#);
- discussion with staff and observation of interactions demonstrate patients are treated with dignity and respect;
- there is a suitable location for private consultation;
- there is a policy and procedure on maintaining confidentiality which is regularly assured;
- patient's modesty and dignity is respected at all times;
- patients and or their representatives rights to make decisions about care and treatment are acknowledged and respected;
- patients and visitors are treated and cared for in accordance with legislative requirements for equality and rights; and
- patients are reassured by the certificate of registration displayed in a conspicuous place.

## Indicator C2

Service users are listened to, valued and communicated with, in an appropriate manner.

### Examples of Evidence

#### Informed Consent

- there are arrangements in place to support patients to make informed decisions; and
- there are arrangements for providing information in alternative formats/interpreter services, if required.

#### Breaking Bad News

- patients and relatives have bad news delivered by professionals who are well informed and in a manner that is sensitive and understanding of their needs;
- the patient's consent is obtained before information regarding their bad news is shared with others;
- the procedure for delivering bad news to patients their families and other significant people is developed in accordance with guidance such as [Breaking Bad News regional guidelines 2003](#); and
- the outcome of breaking bad news to patients the options discussed and future treatment plans are recorded and with the patient's consent shared with their general practitioners and relevant health professionals.

### Indicator C3

There are systems in place to ensure that the views and opinions of service users, and or their representatives, are sought and taken into account in all matters affecting them.

#### Examples of Evidence

- patient consultation (patient satisfaction survey) about the standard and quality of care and environment is carried out at least on an annual basis;
- the results of the consultation are collated to provide a summary report;
- the summary report is made available to clients and a subsequent action plan is developed to inform and improve services;
- treatment and care services are planned and developed with meaningful patient involvement; facilitated and supported as appropriate; and provided in a flexible manner to meet individual and changing requirements; and
- reports summarising patients comments and action taken by the organisation are presented regularly to the setting's management group (where appropriate).

## Is the service well led?

**Effective leadership, management and governance which creates a culture focused on the needs and the experiences of service users in order to deliver safe, effective and compassionate care.**

### Indicator L1

There are management and governance systems in place to ensure the overall quality and safety of services provided.

#### Examples of Evidence

##### Governance Arrangements

- where the entity operating the hospital is a corporate body or partnership or an individual owner who is not in day to day management of the hospital, arrangements are in place to ensure the registered person/nominated representative monitors the quality of services and undertakes an unannounced visit to the premises at least six monthly and produces a report of their findings (where appropriate)The registered person/manager ensures the hospital delivers a safe and effective service in line with the legislation, other professional guidance and minimum standards;
- there are arrangements in place for policies and procedures to be reviewed at least every three years;
- policies are centrally indexed, a date of implementation and planned review is recorded and they are retained in a manner which is easily accessible by staff;
- arrangements are in place in relation to medical governance in accordance with the General Medical Council (GMC) guidance document [“Effective clinical governance for the medical profession: A handbook for organisations employing, contracting or overseeing the practice of doctors”](#);
- arrangements are in place to provide evidence of an appropriate review of risk assessments e.g. legionella, fire, Control of Substances Hazardous to Health (COSHH);
- there are clear arrangements for monitoring the quality of clinical care that include as a minimum unplanned return to theatre, peri-operational deaths as defined by the National Confidential Enquiry, unplanned re-admissions to hospital, unplanned transfers to other hospitals, adverse clinical incidents and surgical site infection rates for the hospital;
- the hospital has systems in place to audit the quality of service and includes responding to patient feedback;

- a data protection policy and procedure is in place; and
- all clinical and operational governance committees have clear terms of reference, membership and roles and responsibilities are clearly defined to ensure there is no ambiguity with respect to who has overall responsibility for clinical governance and operational management.

### **Medical Advisory Committee (MAC)**

- there are written terms of reference for the MAC;
- the MAC meets quarterly as a minimum, and arrangements are in place for extraordinary meetings, as necessary;
- the MAC reviews information collated by the registered manager on adverse clinical incidents (broken down by speciality, procedure and by clinical responsibility) on a quarterly basis to include:
  - all deaths at the hospital;
  - all unplanned re-admissions to hospital;
  - all unplanned returns to theatre;
  - adverse incidents;
  - all unplanned transfers to other hospitals or clinics;
  - other relevant clinical incidents;
  - complaints and compliments;
- the MAC advises on corrective action when necessary;
- the MAC advises the hospital on developments in clinical practice;
- the MAC assists the senior management team to assure and evidence safe practice;
- the MAC provides the expertise to discuss and if necessary challenge practice of individual medical practitioners; and
- minutes of MAC meetings accurately reflect discussions progressed, actions agreed and persons responsible for taking forward actions within agreed timescales.

### **Complaints**

- the hospital has a complaints policy and procedure in accordance with the relevant legislation and DOH guidance on complaints handling [Health and Social Care Complaints Procedure \(Revised April 2019\)](#);
- there are clear arrangements for the management of complaints from patients;
- records are kept of all complaints and these include details of all communications with complainants, investigation records, the result of any investigation, the outcome and the action taken;
- staff know how to receive and deal with complaints;
- arrangements are in place to audit complaints to identify trends and improve services provided;
- themes emerging from complaints are analysed with input from the MAC and other relevant governance committees and any themes identified are disseminated to all staff; and
- complaints are triaged to identify if there are any clinical issues which need to be further reviewed in line with Risk Management procedures.

### **Statutory notification of incidents and deaths to RQIA**

- the hospital has an incident policy and procedure in place which includes reporting arrangements to RQIA;
- incidents are effectively documented and investigated in line with legislation;
- all relevant incidents are reported to RQIA and other relevant organisations in accordance with legislation and procedures. [RQIA Statutory Notification of Incidents and Deaths](#); and
- arrangements are in place to audit adverse incidents to identify trends and improve service provided.

### **Equality**

- the management have systems in place to consider equality for patients;

### **Indicator L2**

There are management and governance systems in place that drive quality improvement.

#### **Examples of Evidence**

##### **Quality Improvement**

- there is evidence of a systematic approach to the review of available data and information, in order to make changes that improve quality, and add benefit to the organisation and patients

##### **Quality Assurance**

- arrangements are in place for managing relevant alerts;
- arrangements are in place for staff supervision and appraisal;
- there are procedures to facilitate audit including clinical audit;
- working practices are systematically audited to ensure they are consistent with legislation, best practice guidance and the hospitals documented policies and procedures; and
- results of audits are analysed and actions identified for improvement are embedded into practice.

### **Indicator L3**

There is a clear organisational structure and all staff are aware of their roles, responsibility and accountability within the overall structure.

#### **Examples of Evidence**

- staff are aware of their roles & responsibilities and actions to be taken should they have a concern;
- the registered person/s have understanding of roles and responsibilities under legislation;
- patients are aware of the roles of staff and who to speak with if they need advice or have issue/concerns;
- the registered person is kept informed regarding the day to day running of the hospital;
- the registered person/registered manager requires and ensures all staff abide by published codes or professional practice relevant to their professional role and obtains evidence that professional registration and revalidation requirements are met;
- there are systems in place to ensure that staff receive induction, mandatory training and appropriate training when new procedures are introduced;
- there is a training and development programme that is kept under review and updated at least annually. It reflects the training needs of individual staff and the aims and objectives of the hospital;
- the effect of training on practice and procedures is evaluated as part of quality management; and
- there are opportunities to raise staff awareness through training and education regarding equality legislation to recognise and respond to patients' diverse needs.

##### **Practising Privileges**

- there is a written procedure that defines the process for application, granting, maintenance and withdrawal of practising privileges;
- the MAC makes recommendations to the registered person/manager regarding eligibility for practising privileges;
- there is a written agreement between the medical practitioner and the hospital that sets out the terms and conditions of granting practising privileges; and
- the MAC, together with the registered manager, reviews all members' practising privileges every

two years.

#### **Indicator L4**

The registered person/s operates the service in accordance with the regulatory framework.

#### **Examples of Evidence**

- the statement of purpose and patient guide are kept under review, revised when necessary and updated;
- insurance arrangements are in place for professional indemnity, public and employers liability;
- registered person/s respond to regulatory matters (e.g. notifications, reports/QIPs, enforcement);
- any changes in the registration status of the service are notified to RQIA; and
- the RQIA certificate of registration is on display and reflective of services provided.

#### **Indicator L5**

There are effective working relationships with internal and external stakeholders.

#### **Examples of Evidence**

- arrangements are in place for staff to access their line manager;
- there are arrangements in place to support staff (e.g. staff meetings, appraisal & supervision);
- discussion with staff confirmed that there are good working relationships and that management are responsive to suggestions/concerns;
- there are arrangements for management to effectively address staff suggestions/concerns;
- the registered person/manager has arrangements in place for dealing with professional alert letters, managing identified lack of competency and poor performance for all staff including those with practicing privileges, and reporting incompetence in line with guidelines issued by Department of Health (DOH) and professional regulatory bodies; and
- there is a raising concerns/whistleblowing policy and procedural guidance for staff.

# Inspection Reports

Our inspection reports will reflect the findings from the inspection. Where it is appropriate, a Quality Improvement Plan (QIP) will detail those areas requiring improvement to ensure the service is compliant with the relevant regulations and standards as a minimum. Where no areas for improvement result from the inspection this will be reflected in the report.

Once the inspection report is finalised and agreed as factually accurate, it will be made public on RQIA's website.



The Regulation and Quality Improvement Authority  
9th Floor  
Riverside Tower  
5 Lanyon Place  
BELFAST  
BT1 3BT

**Tel** 028 9536 1111  
**Email** [info@rqia.org.uk](mailto:info@rqia.org.uk)  
**Web** [www.rqia.org.uk](http://www.rqia.org.uk)  
 [@RQIANews](https://twitter.com/RQIANews)