The Regulation and Quality Improvement Authority

Unannounced Inspection Report

16 May 2022

Orthoderm Clinic

Type of service: Independent Hospital
Address: 2 Ballynahinch Road, Hillsborough, BT26 6AR
Telephone number: 028 9268 0940

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/The Independent Health Care Regulations (Northern Ireland) 2005 and Minimum Care Standards for Independent Healthcare Establishments

1.0 Service information

Organisation/Registered Provider: Orthoderm Ltd **Responsible Individual:** Mr. Michael Harvey Alexander Eames	**Registered Manager:** Mrs. Andrea Michelle Pollock **Date registered:** 25 January 2018
Person in charge at the time of inspection: Mr Michael Harvey Alexander Eames	**Number of registered places:** Outpatients and day surgery only
Categories of care: Independent Hospital (IH) Acute Hospital (Day Surgery) AH (DS) Prescribed Technologies, Endoscopy PT (E) Private Doctor PD	
Brief description of the accommodation/how the service operates: Orthoderm Clinic provides a wide range of services and treatments, including outpatient services across a range of medical specialties; diagnostic tests and investigations and some surgical day case procedures.	

2.0 Inspection summary

An unannounced inspection was undertaken to Orthoderm Clinic on 16 May 2022 and concluded on 26 May 2022, with feedback to the Registered Manager (RM), Mrs Andrea Pollock , Senior Management Team (SMT), and Governance Lead. The inspection team was made up of care inspectors, pharmacy inspector, and an estates inspector who provided remote support.

This inspection focused on eight key themes: governance and leadership; patient care records; surgical services/theatres; safeguarding; staffing; environment and infection prevention and control (IPC); estates; and medicines management. The inspection also sought to assess progress with any areas for improvement identified within the quality improvement plan (QIP) from the last inspection to Orthoderm Clinic on 28 October 2021.

The inspection team met with a range of staff, including managers, nursing and medical staff, and administrative staff. Aspects of frontline care and practices and the management and oversight of governance across the organisation were reviewed.

It was established that Orthoderm had robust governance and oversight mechanisms to provide assurances relating to medical and clinical governance, management of incidents and care delivery. Examples of good practice were evidenced relating to environmental cleanliness, audits and records management. There was evidence of good communication systems to ensure key information is received by staff.

No areas for improvement (AFIs) were identified during this inspection.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

Prior to the inspection a range of information relevant to the establishment was reviewed. This included the following records:

- the registration status of the establishment;
- written and verbal communication received since the previous inspection;
- the previous inspection reports;
- QIPs returned following the previous inspections;
- notifications;
- information on concerns;
- information on complaints; and
- other relevant intelligence received by RQIA.

Inspectors assessed practices and examined records in relation to each of the areas inspected and met with the registered manager, members of the multidisciplinary team (MDT) and the senior management and governance team.

We sought to gather experiences and views from staff and patients available on the day of inspection.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

4.0 What people told us about the service

Posters informing patients, staff and visitors of our inspection were displayed while the inspection was in progress. Staff and patients were invited to complete an electronic questionnaire during the inspection.

Patient questionnaires were distributed during the inspection, no responses have been received.

Several staff interviews took place with medical, nurse, and administrative staff.

We spoke with five staff during the inspection. Fifteen electronic staff questionnaire responses were received, which were all positive in respect of the care they deliver and leadership within the clinic.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to Orthoderm Clinic was undertaken on 28 October 2021; two areas for improvement were identified.

Areas for improvement from the last inspection on 28 October 2021		
Action required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 20 **Stated:** First time	The registered person shall ensure that the domestic store is decluttered and the room refurbished to allow for effective cleaning and reduce risks of cross contamination of equipment.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed the domestic store has been refurbished with extra shelving for storage. A locked Control of Substances Hazardous to Health (COSHH) cupboard is now in place for storage of cleaning agents.	
Action required to ensure compliance with The Independent Healthcare Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 2 **Ref:** Regulation 19 **Stated:** First time	The registered person shall ensure contracted workers, i.e. cleaners, have training commensurate to their role.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed both cleaners have completed training in IPC and COSHH, and certificates were supplied during the inspection.	

5.2 Inspection findings

5.3 Governance and Leadership

5.3.1 Clinical and Organisational Governance

Clear operational structures and accountability arrangements were in place. These arrangements were demonstrated by the holding of various meetings through which assurances were provided to the Responsible Individual. There was a nominated individual with overall responsibility for the day to day management of the clinic. Staff were able to describe their role and responsibilities and confirmed that there were good working relationships with managers, who were responsive to any suggestions or concerns raised.

In line with Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments (2014) clinical governance within Orthoderm clinic was overseen by a Medical Advisory Committee (MAC) and directors meeting. It was evidenced that the MAC meetings were used as a forum to discuss clinical governance issues, performance indicators, and corrective action in relation to adverse clinical incidents. These meetings were being undertaken on average every month, which is in line with the criteria set out in Standard 30. The Chief Executive Officer (CEO) of Affidea Group, who acquired Orthoderm Ltd last year, also attends these meetings.

A range of minutes were reviewed which identified regular SMT meetings and evidenced information is disseminated to staff via to team leads either face to face or via emails.

Documents viewed during the inspection described a wide range of activities which included: monitoring of customer satisfaction; the outcomes of key performance indicators (KPI) audits and incident and trend analysis. Audits were used to assess performance against agreed standards as part of a rolling audit programme. Audits included hand hygiene, environmental, and the use of flexible scopes. Mechanisms were in place to ensure results from the audits were reviewed during the MAC/directors meeting and shared with all staff.

There were good governance systems in place regarding the monitoring of medical and nursing professional bodies' registration.

5.3.2 Practicing Privileges

The clinic has a policy and procedure in place, which outlines the arrangements for application, granting, maintenance, suspension, and withdrawal of practicing privileges, and the management team maintain a robust oversight of these arrangements. There are systems in place to review practising privileges every two years. During the inspection we reviewed personnel files of consultants operating in the clinic, and found that all relevant documentation was present in relation to professional indemnity, insurance and medical appraisals and arrangements for revalidation.

5.3.3 Communication

Policies and procedures were available for staff reference with a system of review in place. Staff reported they were aware of the policies and how to access them.

A procedure for the dissemination and implementation of regional and national guidance, urgent communications, safety alerts and notices was in place to ensure all patient safety communications received were distributed and actioned appropriately in a timely manner.

The communication of information is also provided at staff meetings, by email, and also by information displayed on staff information boards.

The RM shared that the Affidea group provide a monthly press release for all staff and share good news information within it. Staff across all their sites were involved in a walking 'Steps Challenge' in January. The RM also advised they had recently received confirmation that they had attained re accreditation in their Investors in People (IIP) standard award which highlighted their investment in their staff and their core values. Affidea held thank you lunches for these events for staff. Staff and SMT expressed good engagement and support from Affidea.

Moving forward, the RM is hoping to have monthly meetings with an affiliate clinic, which has also been acquired by the Affidea Group. It is hoped this will be a mechanism to share any learning or benchmarking across the two sites.

5.3.4 Complaints Management

Copies of the complaints procedure and whistleblowing policy were available and staff were clear on how to raise concerns. Patients are also provided with information on how to raise a complaint. Information recorded for complaints included nature, type of complaint, area involved, risk rating, outcome and complainant satisfaction and whether response timescales were met. Themes emerging from complaints analysis are shared with the MAC and any action taken to address themes is recorded. Learning is disseminated across all staff groups to drive improvement in the quality of this service, which staff confirmed during the inspection. Since our last inspection Orthoderm have received one service user complaint. On review of this during the inspection we were happy it was managed in line with local policy and regulations.

5.3.5 Notifiable events/incidents

Systems are in place to support good risk management within the clinic. This ensures that the likelihood of adverse incidents, risks and complaints are minimised by effective identification, prioritisation, treatment and management.

Risks were documented, collated and tracked through the use of a risk register which provided assurance about the effective identification and management of risk.

Examination of insurance documentation confirmed that insurance policies were in place.

The RQIA certificate of registration was up to date and displayed appropriately.

5.4 Patient Care Records (medical and nursing)

The clinic is registered with the Information Commissioners Office (ICO). Records required by legislation were retained and made available for inspection at all times.

Review of a sample of patients records evidenced they contained information relating to their pre-operative, peri-operative and post- operative care, outlining care planned, decisions made and care delivered. However, one patient record had a small discrepancy in relation to the surgical pause section which was addressed with the theatre manager during the inspection.

Assurances were given this would be followed up with staff and also through audit. It was noted that auditing of these records is carried out six monthly and recommended this should be increased to ensure trends identified are dealt with promptly.

There is an up to date policy in place for records retention schedule. Records are held in a secure environment. Computerised records were accessed using individual username and passwords. The clinical director reported issues in relation to accessing Electronic Care Records (ECR) and the potential safety issues this may cause. ECR is the system that health and social care staff use to obtain information about a patient's medical history. RQIA have and will continue to engage with the relevant bodies to highlight these concerns.

5.5 Surgical Services/Theatres

A review of the arrangements for the provision of surgery in the clinic found them operating under their statement and purpose and categories of care. It was confirmed that the clinic provides a limited day surgical service and endoscopy service (cystoscopy only) under local anaesthetic as appropriate. No procedures are undertaken using general anaesthetic. It was confirmed that a number of consultants from orthopaedics, plastic surgery, dermatology and urology undertake minor surgical procedures.

There was evidence that there was an identified member of nursing staff, with relevant experience, in charge of the operating theatre at all times. Surgical registers were in place and found to be well recorded in accordance with regulation. It was confirmed no surgical assistants were used in the hospital.

Supplies of sterile instrument packs are obtained from an approved sterile services department under contract from a health and social care Trust. There are robust measures in place to monitor the traceability of all surgical instruments used in the hospital. Clinical equipment was evidenced to be clean and fit for purpose, and traceability labels were used to identify when equipment had been cleaned.

A wide range of comprehensive policies and procedures are in place to ensure that safe and effective care is provided to patients, which are in accordance with good practice guidelines and national standards.

Review of the patient care records and discussion with staff confirmed the consultant performing the procedure meets with the patient prior to the procedure to assess their general medical fitness; discuss the procedure; obtain informed consent; and discuss options for post-operative pain relief. Discharge criteria are in place to check the patient's condition and suitability to transfer from recovery to the waiting area if necessary or to home.
The scheduling of patients for surgical procedures is co-ordinated by the clinical co-ordinator, the consultant and the administration office. The theatre lists take into account the individual requirements of the patient, the type of procedure to be performed, availability of equipment, staffing levels required, and any associated risks.

There was evidence staff used a surgical checklist based on the World Health Organisation (WHO) checklist.

Review of pathology services found there was a clear and robust pathway for the collection of specimens in theatre, inclusive of red flag specimens, which is fully documented. It was confirmed that pathology results are recorded in a log and sent to be assessed by the patients' consultant.

An emergency trolley is located in theatre and checked daily by staff. Drugs and oxygen were all in date. Stock control is in place. A drugs fridge is in use and daily temperature checks are carried out.

5.6 Safeguarding

Arrangements were reviewed for safeguarding of children and adults. Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. Policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or a child.

Staff demonstrated they were aware of types and indicators of potential abuse and the actions to be taken should a safeguarding issue be identified, including who the nominated safeguarding lead in the hospital was.

Review of the staff training matrix evidenced that all relevant staff had received training in safeguarding children and adults and safeguarding leads had received training at a level appropriate to their role.

5.7 Staffing (recruitment and selection, training, supervision and appraisals)

We found evidence that staff were recruited and employed in accordance with relevant employment legislation and best practice guidance. A random sample of staff personnel files were reviewed, inclusive of newly recruited staff, and we evidenced that the information required by legislation was obtained and retained in the files. A review of duty rotas and discussion with staff evidenced that there were sufficient staff in various roles to fulfil the needs of the clinic and patients.

A rolling programme is in place for appraising staff performance and staff confirmed that appraisals had taken place. Supervision is carried out by the RP on an informal basis, and staff can also request supervision as they feel required. Staff told us they felt supported and involved in discussions about their personal development. An online training matrix is maintained and was evidenced during the inspection, with training in date and a rolling programme of updates evidenced. Induction programme templates were in place relevant to specific roles within the hospital.

Staff told us that there were good working relationships throughout the hospital and we found clear evidence of multidisciplinary working.

The governance manager confirmed there is a system in place to review the registration details of all health and social care professionals with their professional bodies. A review of documentation evidenced that doctors who deliver services in the clinic provide evidence of the following:

- confirmation of identity;
- current registration with the General Medical Council (GMC);
- appropriate professional indemnity insurance;
- appropriate qualifications, skills and experience;
- ongoing professional development and continuing medical education that meet the requirements of the Royal Colleges and GMC; and
- ongoing annual appraisal by a trained medical appraiser

The governance manager has confirmed that full medical appraisal documents are received from the associated Trusts

5.8 Environment/Infection Prevention and Control

Overall the environment and equipment were in a good state of repair, with a high standard of cleaning throughout the clinic. We noted the general environment, consultation rooms, and theatres were clean and clutter free. Some COVID measures remain in place and the waiting area remains adjusted to ensure social distancing. SMT should continue to review measures in line with changes to guidance. Hand sanitiser was available at all key points of care in the clinic, and clinical staff were observed to be compliant with dress code and hand hygiene policy.

There were clear lines of accountability regarding infection prevention control (IPC), and there is access to an IPC advisor and microbiologist who support the clinic. The IPC advisor carries out independent audits and links with the clinics Governance Lead to discuss findings. Cleaning schedules were found to be completed for all areas.

5.9 Estates

The following documentation was reviewed in relation to the maintenance of the premises including the mechanical and electrical installations. Discussion with staff demonstrated that suitable arrangements are in place for maintaining the environment in accordance with current legislation and best practice guidance.

- the Fire Risk Assessment;
- service records for the premises fire alarm and detection system;
- service records for the premises emergency lighting installation;
- service records for the premises portable fire-fighting equipment;
- records of fire drills undertaken;
- Lifting Operations and Lifting Equipment Regulations (LOLER) 'Thorough Examination' reports of the premises' stair lifts;
- condition report for the premises' fixed wiring installation;
- gas safe certification;
- report for the formal testing of the premises' portable electrical appliances;
- the Legionella Risk Assessment; and
- service records, validation checks and audits for the premises' critical ventilation systems.

The premises general mechanical and electrical systems are currently being serviced and maintained in accordance with current regulations and best practice guidance.

The most recent Legionella Risk Assessment was undertaken on 18 November 2021 and no significant actions were noted. Suitable control measures and temperature monitoring of the premises' hot and cold water systems was in place with records being maintained as recommended.

The current Fire Risk Assessment was reviewed on 5 May 2022. The overall assessment was assessed as 'tolerable' and no significant findings were identified. The most recent fire drill for the premises was undertaken on the 30 September 2021. Any issues identified during this drill were immediately followed up by management and advice issued to staff.

The premises' critical ventilation systems are serviced in accordance with current best practice guidance and suitable validation is undertaken in accordance with the current health technical memoranda. Records and validation reports were available and reviewed at the time of the inspection.

5.10 Medicines Management

Written policies and procedures for the management of medicines were up to date and covered all aspects of medicines management.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Records of orders and receipts were retained. Staff were reminded that receipts should be signed and dated.

There were policies in place to ensure the safe management of medicines during procedures and on patient discharge.

A sample of medicine records were provided for inspection. They had been clearly and appropriately completed by the consultants. Medicines given to patients on discharge are clearly labelled with the dosage instructions. A record of the medicines issued to patients was made.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. Medicine refrigerators and the contents of the emergency trolley were checked at regular intervals.

There is an effective system in place for the management of drug alerts, medical device alerts and safety warnings about medicines.

There were robust arrangements in place for the management of medicine related incidents. The registered manager confirmed that they knew how to identify and report incidents. No medicine related incidents had been reported. A clear policy for managing incidents was available for staff reference.

At the time of the inspection there had been no medicines management audits. Staff were in the process of developing this process and advice was provided for good practice in regards to it. Audits are scheduled to be completed on a quarterly basis and will enhance the governance arrangements.

6.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Andrea Pollock, RM, as part of the inspection process and can be found in the main body of the report.

Please ensure this document is completed in full and returned via the Web Portal

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