Unannounced Inspection Report
20 & 27 November 2019

Orthoderm Clinic

Type of Service: Independent Hospital (IH) – Private Doctor
Address: 2 Ballynahinch Road, Hillsborough, BT26 6AR
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Assurance, Challenge and Improvement in Health and Social Care

Membership of the Inspection Team

Jo Browne	Senior Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
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Stephen O'Connor	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
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Gavin Doherty	Inspector, Premises Team Regulation and Quality Improvement Authority

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

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.

3.0 Service details

Organisation/Registered Provider: Orthoderm Ltd **Responsible Individual:** Mr Michael Eames	**Registered Manager:** Mrs Andrea Pollock
Person in charge at the time of inspection: Mr. Michael Eames was available on day 2 of the inspection.	**Date manager registered:** 25 January 2018
Categories of care: Independent Hospital (IH) PT(E) – Prescribed technique Endoscopy PD - Private Doctor	

4.0 Inspection summary

This unannounced inspection of Orthoderm Clinic took us two days to complete. On the first day of the inspection, Wednesday 20 November 2019, the registered manager and the responsible individual of Orthoderm Clinic were not available as they were attending a planned engagement. We however were able to conclude the inspection when both were available on Wednesday 27 November 2019.

This inspection was 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 and the Department of Health (DoH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

We employed a multidisciplinary inspection methodology during this inspection. The multi-disciplinary inspection team examined a number of aspects of the hospital from front line care and practices to management and oversight of governance. We met with various staff members, reviewed care practice and relevant records and documentation to support the organisational governance and assurance systems.

Patients informed us they were happy with their care and were positive regarding their experiences and interactions with all staff. Patients felt safe, secure and well-informed about the care they were receiving. We observed staff treating patients and/or their representatives with dignity, staff were respectful of patients' right to privacy.

No immediate concerns were identified in relation to delivery of front line patient care. We noted multiple areas of strength, particularly in relation to organisational management and the delivery of care.

Examples of good practice were evidenced in all four Domains. The four domains are outlined in section 1.0 of this report. These related to staff appraisal and supervision, the provision of surgical services, the environment, management of the patients' care pathway, communication, practising privileges arrangements and engagement with patients to enhance their experience. Areas requiring improvement were identified in relation to infection prevention and control (IPC) arrangements, policies and procedures and audit. An area for improvement against the standards was made in this regard.

The findings of this report will provide the establishment with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

One area for improvement against the standards was identified in relation to IPC policies, procedures and the IPC audit programme.

On 27 November 2019, we provided feedback to Mrs Pollock, Registered Manager and the Human Resources Manager. During this meeting, we discussed the establishment's strengths and the areas requiring improvement identified during our inspection.

We discussed the actions, which are required within the Quality Improvement Plan (QIP). The timescales for completion of these actions commence from the date of our inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Enforcement taken following this inspection

Other than those actions detailed in the QIP no further actions were required to be taken.

5.0 How we inspect

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

- notifiable events since the previous care inspection;
- the registration status of the establishment;
- written and verbal communication received since the previous care inspection; and
- the previous care inspection report.

During our inspection, we spoke with patients and distributed questionnaires to patients. Returned completed patient questionnaires were analysed following the inspection. RQIA invited staff to complete an electronic questionnaire during the inspection. We did not receive any completed staff questionnaires during or following the inspection.

Posters informing patients, staff and visitors of our inspection were displayed while our inspection was in progress.

During our inspection, we met with the following staff, Mr Eames, Responsible Individual, Mrs Pollock, Registered Manager, and the Human Resources Manager. We also took the opportunity to speak to the Lead Nurse and a number of staff working in the establishment.

We inspected the reception area, waiting areas, consultation rooms, the main theatre and adjoining recovery area, theatre two, treatments rooms, store rooms, sluice and patient toilet areas.

As part of the inspection a sample of records was examined during the inspection in relation to each of the areas inspected.

We provided detailed feedback on our inspection findings as described in section 4.1.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection on 12 February 2019

The previous inspection of the establishment was an announced care inspection undertaken 12 February 2019. No premises or pharmacy inspections were carried out at this time.

6.2 Review of areas for improvement from the last care inspection on 12 February 2019

There were no areas for improvement made as a result of the last care inspection.

6.3 Inspection findings

6.4 Is the service well led?

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

6.4.1 Clinical and organisational governance

We examined various aspects of the governance systems in place. There was a clear organisational structure within the hospital and staff were able to describe their roles and responsibilities and were aware of whom to speak to if they had a concern. Staff confirmed to us that there were good working relationships and that management were responsive to any suggestions or concerns raised. There was a nominated individual with overall responsibility for the day to day management of the hospital.

We reviewed a sample of records and minutes of meetings and discussed the hospital's governance arrangements and managerial oversight with a number of staff. This included meeting with Mr Eames, Responsible Individual, Mrs Pollock, Registered Manager and the Human Resources Manager.

We found that policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, dated and systematically reviewed on a three yearly basis. Staff who spoke with us were aware of the policies and how to access them.

6.4.2 Medical governance and Medical Advisory Committee

We found that systems were in place to ensure that the quality of services provided by the hospital. The hospital has a defined clinical governance structure in place with regular clinical meetings involving all areas of the hospital and an additional directors meeting. In line with Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments (July 2014) we were unable to evidence an established Medical Advisory Committee (MAC) with terms of reference or standard agenda. On discussion it was evident that the clinical meeting and directors meeting (attended by the hospital directors) was fulfilling this criterion. It is suggested that the establishment update its governance and meeting composition to align with Standard 30.

6.4.3 Regulation 26 unannounced quality monitoring visits

Where the entity operating an establishment is a corporate body or partnership or an individual owner who is not in day to day management of the establishment, Regulation 26 unannounced quality monitoring visits must be undertaken and documented every six months.

We confirmed that Mr Eames (Responsible Individual) undertakes a visit to the premises at least every six months in accordance with legislation and reports of the unannounced monitoring visits were available for inspection. We reviewed the reports, found them to be of a high standard and fully compliant with the requirements of Regulation 26.

6.4.4 Complaints management

We confirmed that the hospital has a comments and complaints policy and procedure in place and this is made available for patients/and or their representatives. We found that the contact details for RQIA were out of date. We advised that these should be updated and the policy should reflect the role of RQIA as the regulator and not as a referral route for second stage investigation of complaints. We also advised that the contact details for the Health and Social Trusts and the Ombudsman should be provided for any HSC patients availing of services who remain dissatisfied with local resolution.

Staff who spoke with us demonstrated a good awareness of the processes for management of complaints and staff receive complaints awareness training on an annual basis.

We noted that there have been no complaints received in 2019. We were advised that any complaints received would be raised through the governance systems of the hospital and would be investigated and responded to appropriately. We confirmed that records would be kept of all complaints and would include details of all communications with complainants; the result of any investigation; the outcome and any action taken to address the concerns. We were advised that complaints would be audited to identify patterns and trends and that any learning would be shared with staff in order to improve care and service delivery.

6.4.5 Notifiable events/incidents

We reviewed the arrangements in respect of the management of notifiable events/incidents and found that all incidents were appropriately reported by the hospital to RQIA. We found that a robust incident management policy and procedure was in place.

We were advised that Mrs Pollock and the Human Resources Manager review safety alerts and notices received and ensure that appropriate action is taken to address any issues that would affect Orthoderm Clinic. A record is retained of the relevant safety alert and the action taken. We found that email and daily staff briefings are in place to enhance communication and ensure that urgent communications are made available to key staff in a timely manner.

6.4.6 Practising privileges

We reviewed the arrangements relating to practising privileges for medical practitioners working within the hospital. A practicing privileges policy and procedure was in place which outlines the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges.

Mr Eames outlined the process for granting practising privileges and confirmed medical practitioners meet with the directors prior to privileges being granted. There are systems in place to review practising privileges agreements every two years. All medical practitioners working within the hospital have designated external Responsible Officers. In accordance with the General Medical Council (GMC) all doctors must revalidate every five years. The revalidation process requires doctors to collect examples of their work to understand what they're doing well and how they can improve. A network of experienced senior doctors (called responsible officers) work with the GMC to make sure doctors are reviewing their work. As part of the revalidation process RO's make a revalidation recommendations to the GMC. Discussion with Mr Eames confirmed that he was linked in to the RO network.

We reviewed three medical practitioner's personnel files and confirmed that there was a written agreement between each medical practitioner and the hospital setting out the terms and conditions of practising privileges, which had been signed by both parties. We found that robust arrangements were in place for the management of practising privileges.

6.4.7 Risk registers

We were advised that Orthoderm Clinic maintains a corporate risk register. Review of this register evidenced that it included risks in relation to all areas of the hospital that have the potential to impact on the delivery of services. We confirmed that the risk register included actions to mitigate against identified risks and that it is routinely reviewed through the hospital governance structures.

6.4.8 Quality assurance

Mrs Pollock confirmed to us that arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals. These included audits in relation to clinical management, booking arrangements and health and safety. If required, an action plan was developed and embedded into practice to address any shortfalls identified during the audit process.

6.4.9 Management of operations

We found that there was a clear understanding of the organisational structure within the hospital. Mrs Pollock is the Registered Manager and has overall responsibility for the day to day management of Orthoderm Clinic. Staff who spoke with us were able to describe their roles and responsibilities and were aware of who to speak to if they had a concern. There was a system in place to ensure that urgent communications, safety alerts and notices are reviewed and where appropriate, made available to key staff in a timely manner.

We confirmed that the hospital has arrangements in place to monitor the competency and performance of all staff and report to the relevant professional regulatory bodies in accordance with best practice guidance. There are also systems in place to check the registration status of the health care professionals with their appropriate professional bodies on an annual basis.

We reviewed and confirmed that the statement of purpose and patient's guide are kept under review, revised and updated when necessary and these are available on request.

We observed that the RQIA certificate of registration was up to date and displayed appropriately. Review of insurance documentation confirmed that current insurance policies were in place.

The hospital has a Whistleblowing policy and procedure in place to enable staff to report concerns they may have regarding poor practice. Staff who spoke with us confirmed that they were aware of the policy and who to contact if they had any concerns.

Areas of good practice: Is the service well led?

We found examples of good practice in relation to organisational governance; the management of complaints and incidents; and quality assurance.

Areas for improvement: Is the service well led?

No areas for improvement were identified during the inspection in relation to the hospital being well led.

	Regulations	Standards
Areas for improvement	0	0

6.5 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

6.5.1 Staffing

We reviewed the staffing arrangements within the hospital. Discussion with Mrs Pollock, the Human Resource Manager and staff demonstrated that there was sufficient staff in various roles to fulfil the needs of the hospital and patients.

We were advised by the management team that no new staff have been recruited since the previous care inspection, however, it was confirmed that all new staff undertake an induction. We reviewed the range of induction templates available for specific roles within the hospital and found these to be satisfactory standard.

Procedures were in place for appraising staff performance and staff confirmed to us that appraisals had taken place. Review of the electronic records provided by senior management evidenced that appraisals had been completed on an annual basis.

We found that there were systems in place for recording and monitoring all aspects of staff ongoing professional development, including specialist qualifications and training. Staff reported they felt supported and involved in discussions about their personal development.

Discussion with the Human Resources Manager and review of a sample of training records confirmed that the hospital provides annual mandatory training appropriate to staff roles and responsibilities. Examples of mandatory training delivered included, fire safety awareness, infection prevention and control, basic and intermediate life support, safeguarding and manual handling. We also noted that wound management training was provided during December 2019. The hospital affords staff opportunities to undertake specialist qualifications such as wound care management.

Arrangements were in place to ensure that all health and social care professionals are aware that they are accountable for their individual practice and adherence to professional codes of conduct.

Discussion with the Human Resources Manager confirmed that a robust system was in place to review the professional indemnity status of all staff that require individual indemnity cover. Review of personnel files confirmed that Medical Practitioners had appropriate professional indemnity insurance in place.

We found that there was a process in place to review the registration details of all health and social care (HSC) professionals. We reviewed the personnel files of HSC Medical Practitioners; Consultants operating during the course of the inspection and the identified Private Doctors' and evidenced the following was in place:

- 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.

6.5.2 Recruitment and selection

We reviewed how recruitment and selection of staff is undertaken by the hospital. We found there was a recruitment and selection policy and procedure available which was comprehensive and reflected best practice guidance.

As previously stated, Mrs Pollock and the Human Resources Manager confirmed that no new staff have been recruited since the previous inspection. We were assured that, should staff be recruited in the future robust systems and processes are in place to ensure that all recruitment documentation as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 would be sought and retained for inspection.

6.5.3 Surgical services

We reviewed the provision of surgical services within the hospital. We found that the hospital has a wide range of comprehensive policies and procedures in place to ensure that safe and effective care is provided to patients, which are in accordance with good practice guidelines and national standards.

Within the hospital, there is a defined staff structure for surgical services, which clearly outlines areas of accountability and individual roles and responsibilities. The scheduling of patients for surgical procedures is co-ordinated by the hospital co-ordinator, the consultant Medical Practitioner 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 associated risks. Mrs Pollock confirmed that all procedures are undertaken as day surgery cases using local anaesthesia, where necessary. No procedures are performed under general anaesthesia.

Staff who spoke with us confirmed that the Consultant performing the surgical procedure meets with the patient, prior to commencing the procedure, to discuss the surgery and anaesthesia used, obtain informed consent and agree options for post-operative pain relief.

We confirmed there is an identified member of nursing staff, with theatre experience, in charge of the operating theatre. Discussion with staff confirmed that patients are observed during and immediately following surgery. Discharge criteria is in place to check the patient's condition and appropriateness to transfer to the waiting area or home following the procedure. We were advised that the Consultant who performs the procedure confirms when the patient is suitable for discharge from the hospital.

We reviewed the surgical register of operations, which is maintained for all surgical procedures undertaken in the hospital and found that it contained all of the information required by legislation. Staff informed us that the surgical checklist used in the hospital was adapted from the World Health Organisation (WHO) checklist.

6.5.4 Safeguarding

We reviewed the arrangements in place for safeguarding and found that policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. The policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The relevant contact details for onward referral to the local Health and Social Care Trust (HSCT) should a safeguarding issue arise were included. It was confirmed that copies of the regional policy entitled 'Co-operating to Safeguard Children and Young People in Northern Ireland' (August 2017) and the regional guidance document entitled 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015) were both available for staff reference

We discussed safeguarding with staff and found good general awareness of the types and indicators of abuse, along with the actions to be taken in the event of a safeguarding issue being identified. Staff were able to identify the nominated safeguarding lead for the hospital.

A review of records demonstrated that all staff in the hospital had received training in safeguarding children and adults as outlined in the Minimum Care Standards for Independent Healthcare Establishments July 2014.

The hospital provides outpatient services for children and staff who spoke with us and the Human Resources Manager advised that a parent or guardian must be present during the child's at all times.

We were advised of potential plans to develop the hospital's surgical procedures to include children. These will be carried out by a Consultant Paediatrician, supported by a paediatric nurse. Work to progress this area is in its early stages and moving forward should include discussion with the aligned care inspector to ensure adherence to legislative requirements.

6.5.5 Resuscitation and management of medical emergencies

We reviewed the arrangements for the management of a medical emergencies and resuscitation of patients and visitors to the hospital. The hospital has a policy and procedure for dealing with medical emergencies and cardio pulmonary resuscitation (CPR) that was in accordance with the Resuscitation Council UK guidelines. Discussion with staff demonstrated that they had a good understanding of the actions to be taken in the event of a medical emergency and the location of medical emergency medicines and equipment.

We reviewed the emergency trolley and evidenced that emergency medicines and equipment were available. We were informed that a decision was made by the hospital to review and reduce the emergency medicines and equipment retained following a review of best practice literature and completion of a risk assessment based on the hospital's activity. This risk based approach was considered to be appropriate and should be reviewed regularly, particularly if the profile of the hospital or the patient demographics change. We noted that a system was in place to ensure that emergency medicines and equipment do not exceed their expiry date.

A review of training records and discussion with staff confirmed that staff have undertaken basic life support training and updates and all permanent nursing staff had received intermediate life support training and updates. We were advised that staff involved in the provision of paediatric care have also received paediatric life support training.

6.5.6 Infection prevention control (IPC) and decontamination procedures

We reviewed the arrangements for infection prevention and control and the decontamination procedures in place throughout the hospital, to ensure that the risk of infection for patients, visitors and staff are minimised. We found there were clear lines of accountability for infection prevention and control and the hospital has a designated IPC Lead Nurse.

We reviewed a range of IPC policies and procedures which were located within an IPC manual. We identified that these policies (while in date) required to be updated to include best practice with regards to aseptic non touch technique (ANTT) and the seven step hand hygiene procedure in line with regional policies and procedures.

We found arrangements were in place to ensure the decontamination of equipment and reusable medical devices in line with manufacturer's instructions and current best practice. Flexible cystoscopes and reusable medical instruments are decontaminated within the Health and Social Care Central Sterile Services Department (CSSD). Staff who spoke with us advised that single use equipment is used where possible.

We were advised that members of the nursing team attended training at the Ulster Hospital CSSD in respect of the pre-cleaning and packing of flexible cystoscopes for transportation to CSSD. This training was then cascaded to other staff in the hospital, where applicable. Ulster Hospital CSSD staff visited the hospital and provided advice on developing a procedure for pre-cleaning and packing of flexible cystoscopes. There was no audit process in place to provide assurance that staff were adhering to this procedure. We were advised by the Lead Nurse that this will be introduced immediately.

We found that staff had been provided with IPC training commensurate with their role. We discussed IPC with staff and found that they had a good knowledge and understanding of IPC procedures and practices.

We reviewed a range of IPC audits that had been carried out including:

- clinical waste control;
- sharps – safe disposal; and
- environmental cleaning.

We noted that the compliance rate was very high and action plans were in place to address any areas of non-compliance. Through discussion with staff in relation to cleaning practices we identified that mops heads were not always changed daily and this was not captured as part of the cleaning audit. We found that no audits were carried out on staff clinical practices.

We found that the hospital was clean, tidy and well maintained. Personal protective equipment (gloves, aprons, facemasks) were available for staff. Hibiscrub and alcohol hand santiser was available for hand hygiene; however handwashing soap was not present in the domestic store or small treatment room. We observed the handwashing sink within the recently refurbished treatment room was not in line with clinical handwashing specifications as an overflow was present.

We evidenced that there were detailed cleaning schedules in place for all areas which were signed on completion and we observed that a colour coded cleaning system was in use in accordance with best practice guidance.

We were advised that the hospital has access to an external microbiologist and estates personnel for advice and we suggested that they would benefit from engaging an IPC specialist Nurse to augment this service.

Our review of infection prevention and control arrangements, policies and procedures and audit indicated that infection control practices should be further developed within the hospital. An area for improvement against the standards has been made in this area.

6.5.7 Environment

We found that the environment of the hospital was overall maintained to a high standard of maintenance and décor. However we noted some minor wall damage and maintenance required in patient toilet areas and we were told of future plans to redecorate these facilities.

We reviewed documentation in relation to the maintenance of the premises including mechanical and electrical services. Discussion with the Human Resources Manager demonstrated that suitable arrangements are in place for maintaining the environment in accordance with current legislation and best practice guidance. The following documents were reviewed:

- fire risk assessment;
- fire alarm and detection system including weekly user checks;
- emergency lighting installation including monthly user checks;
- portable fire-fighting equipment including monthly user checks;
- passenger lift service contract;
- Lifting Operations and Lifting Equipment (LOLER) Thorough Examination of lifting equipment;
- legionella risk assessment;
- fixed electrical installation certificate;
- portable appliance testing;
- 'Gas Safe' certification;
- boiler and space heating service contract; and
- mechanical ventilation systems service contract and validation reports.

The most recent legionella risk assessment was undertaken on 11 September 2019 and the identified significant findings had been suitably addressed by 29 October 2019. Suitable control measures were in place and maintained in accordance with current best practice guidance.

A fire risk assessment had been undertaken on 29 January 2019 and the identified significant findings had been suitably addressed by 29 March 2019. The records we reviewed confirmed that fire safety training was maintained for all staff and the most recent fire drill was undertaken 11 December 2018. Staff who spoke with us demonstrated that they were aware of the action to take in the event of a fire.

We found that the premises mechanical ventilation systems had been installed and maintained in accordance with the current best practice guidance contained in the relevant Health Technical Memoranda. A service contract was in place and the most recent service was undertaken on 29 October 2019. Annual validation of the systems is undertaken by the premises Authorised Engineer (Ventilation) and the most recent report undertaken on 11 October 2019 contained no significant findings.

On 11 October 2018 Orthoderm Ltd submitted a variation to registration application to reconfigure the kitchen on the ground floor to a minor operating theatre and re-establish the kitchen on the first floor. We reviewed the work carried out at the time of the inspection and confirmed that suitable mechanical ventilation is now provided to this area, the variation to registration was approved by the premises inspector.

6.5.8 Medicines Management

We reviewed the arrangements in place for the management of medicines within the hospital to ensure that medicines are safely, securely and effectively managed in compliance with legislative requirements, professional standards and guidelines.

We found that policy and procedure documents for the management of medicines were in place and up to date and available for staff reference. The nursing staff who spoke with us demonstrated a good knowledge of the medicines management policy and procedures.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available. We were advised that medicines were obtained from a local community pharmacy. No controlled drugs were held in stock or in use.

Medicines were observed to be stored safely and securely and in accordance with the manufacturer's instructions. However, we advised nursing staff to reset the medicines refrigerator thermometer on each occasion after recording temperatures and to record both the maximum and minimum refrigerator temperatures in addition to the current temperature. This is to ensure that the temperature remains in the appropriate range of 2-8°C at all times. It was agreed that this would be implemented immediately.

We reviewed medicine records and found they were legible and well maintained. These included records of medicines ordered and received and medicines administered. There were suitable records maintained regarding treatment provided and outcomes and any medicines administered and prescribed. Patients were provided with information regarding their treatment and any medicines prescribed by the Medical Practitioners. A copy of any prescription was shared with the patient's General Practitioner. No medicines were dispensed directly to patients from the hospital for use at home.

There were systems in place for identifying, recording, reporting, analysing and learning from adverse incidents and near misses involving medicines and medicinal products. Staff advised that any incidents and learning would be shared with relevant staff.

There were systems in place for the management of drug alerts, medical device alerts and safety warnings about medicines.

Areas of good practice: Is care safe?

We found examples of good practice in relation to staff recruitment; induction; training; supervision and appraisal; safeguarding; management of medical emergencies; the environment; and the management of medicines.

Areas for improvement: Is care safe?

We identified an area for improvement to further develop and strengthen IPC policies and procedures.

	Regulations	Standards
Areas for improvement	0	1

6.6 Is care effective?

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

6.6.1 Care pathway

We reviewed the patient care pathway through the hospital. We found that patients are provided with comprehensive information prior to their surgical procedure which outlines any pre-operative and post-operative requirements.

We reviewed a sample of patient records and found that the care records contained comprehensive information relating to pre and post-operative care which clearly outlined the patient pathway and included the following:

- patient personal information;
- pre-operative care plans;
- pre-operative checks;
- signed consent forms;
- surgical safety checklist;
- procedure notes;
- medical notes;
- post-operative checks; and
- discharge plan.

As previously stated, we were advised that patients attending for a surgical procedure meet with their Consultant prior to going for the procedure to discuss the nature of the procedure, the risks, complications and expected outcomes before signing the consent form. The consent forms we reviewed were signed by the Consultant Surgeon and the patient.

6.6.2 Records Management

We reviewed the management of records within the hospital. The hospital is registered with the Information Commissioner's Office (ICO). Through discussion with staff it was confirmed that the hospital is aware of and is complying with the General Data Protection Regulations that came into effect during May 2018.

Staff who spoke with us confirmed they had a good knowledge of effective records management. The hospital has a range of policies and procedures in place for the management of records which includes the arrangements for the creation; use; retention; storage; transfer; disposal; of and access to records. A policy and procedure was in place for clinical record keeping in relation to patient treatment and care which complies with (GMC) guidance and Good Medical Practice.

The management of records within the hospital was found to be in line with legislation and best practice. Patient records were held in secure cabinets and computerised records were accessed by only those with password permission. Records required by legislation were retained and made available to us.

We identified the establishment Data Breach Notification Policy did not make reference to informing RQIA in the event of a data breach. In addition, the Records Information Management Policy and Procedure did not provide guidance to Medical staff on retaining records outside of the establishment. The Human Resources Manager agreed to immediately revise and update these policies.

We found systems were in place to audit theatre and physio record keeping as outlined in the establishments audit programme.

6.6.3 Discharge planning

We found robust systems were in place to ensure that agreed discharge arrangements are recorded and co-ordinated with all other professionals that are involved in the patient's ongoing care and treatment.

We reviewed the discharge arrangements and established that discharge criterion is in place and we were advised the Consultant who performs the procedure confirms the patient's suitability for discharge from the hospital.

A clinical discharge summary is completed prior to the patient leaving the hospital. A discharge letter is provided to the patient's General Practitioner (GP) to outline the care and treatment provided within the hospital.

Areas of good practice: Is care effective?

We found examples of good practice in relation to record keeping; record management; and discharge planning.

Areas for improvement: Is care effective?

No areas for improvement were identified during the inspection in relation to effective care.

	Regulations	Standards
Areas for improvement	0	0

6.7 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

6.7.1 Person centred care

We reviewed care records, observed practice and met with various grades of staff to understand how the hospital ensures that patients receive person centred care; we found good systems in place across the hospital.

Patients told us they were very happy with their care and we observed positive interactions between staff, patients and their relatives throughout our inspection. We observed staff treating patients with compassion, dignity and respect, introducing themselves and explaining procedures to patients in a kind and caring manner.

During the consultation and treatment processes we observed that patients' modesty and dignity was respected at all times.

6.7.2 Breaking bad news

We confirmed that the hospital has a Breaking Bad News Policy for delivering bad news to patients and/or their representatives which is accordance with the Breaking Bad News Regional Guidelines 2003.

We spoke with staff who confirmed that bad news is delivered to patients and/or their representatives by professionals who have experience in communication skills and act in accordance with the hospital's policy.

Where bad news is shared with others, staff confirmed that consent must be obtained from the patient and this is then documented in the patient's records. Following a patient receiving bad news, future treatment options are discussed fully with the patient and documented within their individual care records. Staff provide support to the patient and/or their representative to help them process the information shared. We were advised that information is shared with the patient's GP and/or other healthcare professionals involved in their ongoing treatment and care.

6.7.3 Patient engagement

We examined the methods used by the hospital to obtain the views of patients and/or their representatives. We found this to be an integral part of the services delivered. Patients are offered an opportunity to provide feedback on their care through completion of a questionnaire.

We found that information received from these questionnaires was available to patients and other interested parties within an annual report which is made available through the hospital's website. We reviewed the most recent annual report and noted that patients were highly satisfied with the care and treatment provided.

Mrs Pollock informed us that comments received from patients and/or their representatives are reviewed by senior management and used to improve the quality of services delivered. An action plan is developed and implemented to address any issues identified.

Areas of good practice: Is care compassionate?

We found examples of good practice in relation to ensuring the core values of privacy and dignity were upheld; arrangements for delivering bad news in a compassionate and supportive manner; and considering feedback from patients to improve the quality of services provided.

Areas for improvement: Is care compassionate?

No areas for improvement were identified during the inspection in relation to compassionate care.

	Regulations	Standards
Areas for improvement	0	0

6.8 Equality data

The arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients was discussed with Ms Pollock.

6.9 Patient and staff views

During our inspection, the hospital distributed patient questionnaires on our behalf for completion and return to RQIA. We received four completed patient questionnaires and found that patients who responded were very satisfied that the hospital was providing safe, effective, compassionate and well led care. We did not receive any comments from patients in the completed questionnaires.

We invited staff to complete an electronic questionnaire during the inspection. We did not receive any completed staff patient questionnaires following the inspection however staff who spoke with us reported that they felt supported and valued by the senior management team in the hospital.

7.0 Quality improvement plan (QIP)

An area for improvement was identified during this inspection and is detailed in the QIP. Details of the QIP were discussed with Mrs Pollock, Registered Manager and the Human Resources Manager as part of the inspection process. The timescales commence from the date of inspection.

The Registered Provider/Manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action. It is the responsibility of the Registered Provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the independent hospital. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

An area for improvement has been identified where action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health (DoH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the area for improvement identified. The Registered Provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan	
Action required to ensure compliance with The Minimum Care Standards for Independent Healthcare Establishments (2014)	
Infection Prevention and Control	
Area for improvement 1 **Ref**: Standard 20 **Stated:** First time **To be completed by:** 19 February 2020	The Responsible Person shall ensure: • IPC policies and procedures are reviewed and updated in line with regional and best practice IPC guidelines e.g. to include aseptic non touch technique (ANTT) and hand hygiene; • the pre-cleaning and packing of flexible cystoscopes should be audited to ensure best practice guidance is being adhered to; • the IPC environmental cleaning audit tool should be reviewed and updated to ensure it captures all aspects of environmental cleaning; and • consider engaging the services of an IPC specialist nurse to augment IPC advice and support. Ref:6.5.6
	Response by Registered Person detailing the actions taken: 1. IPC policies and procedures have been reviewed and updated in line with regional and best practice and public health guidelines. An ANTT policy and hand hygiene procedure (which includes the 7 steps handwashing technique and the WHO 5 moments of hand hygiene) have been developed and these link to our Infection Prevention Control Policy. 2. An audit for pre-cleaning and packing of flexible cystoscopes has been developed and is currently in use when flexible cystoscopy lists are running at Orthoderm. Hand hygiene and ANTT audit tools have also been developed. 3. The IPC environmental cleaning audit tool has been reviewed to ensure it includes all environmental cleaning requirements. We feel this audit tool is comprehensive and incorporates all areas within the Clinic. 4. To help us improve and to provide advice and support, we engaged the services of a bacteriologist who visited the clinic to review our current working practices. He also reviewed our IPC policies and procedures and maintenance regimes. We have also taken on board and acted upon other suggestions detailed within the report.

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

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