The Regulation and Quality Improvement Authority

Inspection Report

28 October 2021

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 (July 2014)

1.0 Service information

Organisation/Registered Provider: Orthoderm Ltd **Responsible Individual:** Mr. Michael Harvey Alexander Eames	**Registered Manager:** Mrs. Andrea Michelle Pollock
Person in charge at the time of inspection: Mrs. Andrea Michelle Pollock	**Date manager registered:** 25 January 2018
Categories of care: Independent Hospital (IH) – Acute Hospital (Day Surgery) AH(DS) Prescribed Technologies, Endoscopy PT(E) Private Doctor PD	**Number of registered places:** Outpatients and day surgery only
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 28 October 2021 and concluded on 12 November 2021, with feedback to the manager, Mrs Andrea Pollock. The inspection team was made up of care inspectors and an estates inspector who provided remote support.

This inspection focused on eight key themes: governance and leadership; patient care records; estates; surgical services; environment and infection prevention and control (IPC); safeguarding; and staffing'; 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 5 March 2021.

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

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.

Patients told us they were happy with the care and advice/guidance provided to them by the hospital staff.

Two areas for improvement (AFIs) were identified during the inspection; one relating to the Medical Advisory Committee (MAC) and one in relation to training for the contracted cleaners.

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.

Experiences and views were gathered from staff and patients.

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.

Four patient questionnaires were received by RQIA during the inspection. The feedback from patients indicated that they were satisfied with their care and treatment.

Several staff interviews took place with medical, nurse, administrative and domestic staff. We spoke with ten staff during the inspection. We received ten electronic staff questionnaire responses, 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 5 March 2021; no areas for improvement were identified.

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) or known as a directors meeting. The title of these meetings should be changed to the MAC in accordance with Standard 30. This was addressed during the inspection.

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 two months, which is in line with the criteria set out in Standard 30.

While face to face staff meetings had stopped during the COVID 19 pandemic to enable social distancing measures, mechanisms had been put in place to enable meetings using electronic platforms. A range of minutes had been provided which identified regular senior management team (SMT) meetings and dissemination of information via team leads and emails.

The documents received 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, sharps and flexible scopes. Mechanisms were in place to ensure results from the audits were reviewed during the directors meeting.

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

We were advised that the Affidea Group has acquired Orthoderm Limited. The Affidea Group is a provider of diagnostic imaging and outpatient care services. The country manager for the Affidea group has been working with the RM in making improvements in policy and audit. The registration of Orthoderm Ltd has been unaffected by this acquisition.

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. There are systems in place to review practising privileges every two years. The inspection team found that hospital management maintained a robust oversight of arrangements relating to practicing privileges. We reviewed several personnel files of consultants operating during the course of the inspection, and found that all relevant documentation was present in relation to professional indemnity, insurance and medical appraisals.

5.3.3 Communication

Policies and procedures were available for staff reference with a system of review in place. Staff told us 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.

Staff additionally advised that the communication of information is also supplemented at staff meetings, by email, and also by information displayed for staff information boards.

Some minor amendments were required in a couple of the policies; these were addressed during the inspection.

5.3.4 Complaints management

Copies of the complaints procedure and whistleblowing policy were available and staff were clear on how to raise concerns. 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 action taken to address themes is recorded. Learning is disseminated across all staff groups to drive improvement in the quality of this service.

Patients were provided with information on how to raise a complaint

5.3.5 Notifiable events/incidents

Systems are in place to support good risk management within the clinic. This ensures that the chances 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 and provided assurance about the effective identification and management of risk.

Risks were scored according to likelihood and potential consequence to the clinic and individuals were identified who were responsible for managing the risk and taking further actions. A summary of any adverse clinical risks are presented at the directors meetings and corrective action is recorded.

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.

We examined a number of patient care records which on the whole were completed correctly. One consent form examined was not dated, and a number of signatures on the theatre register were difficult to read. These issues were discussed during inspection and at feedback on 12 November 2021.

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 RP reported issues in relation to accessing Electronic Care Records (ECR) and the potential safety issues this may cause. 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 no procedures are undertaken using general anaesthetic; only local anaesthetic is used during procedures. It was confirmed that a number of consultants from orthopaedics, plastic surgery, dermatology and urology undertake minor surgical procedures. There are links with Trust hospitals for equipment provision also decontamination. There is a defined pathway to link with Belfast labs for specimen samples.

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 discuss the procedure and obtain informed consent. 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.

There is an identified member of nursing staff, with relevant experience, in charge during all procedures.

A review of the surgical register which is maintained for all surgical procedures undertaken in the clinic found that it contained all of the information required by legislation. Some staff signatures were noted to be difficult to read. We advised the RM to create a staff signature list which could be kept at the front the register.

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, associated risks and the level of sedation used.

An emergency trolley is located in theatre and checked daily by staff. The oxygen cylinder date was noted to be expired and had been noted on the checklist as in date. This was highlighted during the inspection. No controlled drugs are held, and any other medicines are stored within locked cupboards. Stock control is in place. A drugs fridge is in use and daily temperature checks are carried out. Staff could describe the process for reporting medicine incidents.

5.6 Safeguarding

We reviewed arrangements 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.

It was confirmed that the clinic has one consultant paediatrician who provides services to children for outpatient appointments only. No procedures are carried out on children in the clinic.

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 appraisal).

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.

Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place. 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. 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.

Staff did not regularly receive clinical supervision. We recognise supervision plays an important part in professional development and we would advise that staff complete supervision in line with their professional bodies' guidance/best practice and a written record or evidence of professional supervision having taken place should be retained for inspection. The policy should be reviewed to reflect this.

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.

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. COVID measures remain in place and the waiting area adjusted accordingly to ensure social distancing. Hand sanitiser was available at all key points of care in the clinic, and hand hygiene practices observed were good.

There were clear lines of accountability regarding infection control, and access to an IPC advisor and microbiologist.

It was observed during the inspection that fire doors were wedged open, which we were told was to help air flow. We addressed this at the time due to the fire risks involved.

The domestic store was cluttered and disorganised, and lacked suitable fixtures and fittings for the effective storage of cleaning equipment. It is important that this room is decluttered and improvements made to the fixtures and fittings to allow for effective cleaning, and storage of cleaning equipment. Concerns relating to this were discussed with the RM during the inspection. An AFI will be made in respect of the domestic store.

Cleaning services for the clinic had been sourced from a privately owned business. It was noted that the cleaner has had no formal training in IPC, Control of Substances Hazardous to Health (COSHH), and Health and Safety. This is not compliant with Regulation 19 as any person working within the clinic is required to have the qualifications, skills and experience which are necessary for the work. An AFI will be made in respect of the training requirements for cleaning staff.

5.9 Estates

The Estates section of the inspection was completed remotely. The management team of the clinic were provided with a checklist of estates related items to submit to the estates inspector for review. This included certification relating to the maintenance and upkeep of the building and engineering services as well as relevant risk assessments.

All requested documentation was submitted by the clinic's Human Resources (HR) Advisor and was found to be in order. The maintenance of the building and engineering services is in line with relevant codes of practice and standards, and is carried out by a range of specialist contractors.

The fire risk assessment was carried out by the HR Advisor using a recognised risk assessment format. Two areas requiring attention were identified in the assessment report and these were recorded as being addressed by the HR Advisor.

The legionella risk assessment was carried out by a specialist legionella control company. Three items requiring remedial attention were identified in the assessment report and these were recorded as being addressed by the provider.

Overall, the maintenance and upkeep of the premises' building and engineering services was considered to be satisfactory.

6.0 Quality Improvement Plan/Areas for Improvement

Two areas for improvement have 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).

	Regulations	Standards
Total number of Areas for Improvement	1	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Andrea Pollock, (Registered Manager), and Dr Elizabeth Mc Mullen (Clinical Director) as part of the inspection process. The timescales for completion will commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments	
Area for improvement 1 **Ref:** Standard 20 **Stated:** First time **To be completed by:** 25 November 2021	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. Ref: 5.8
	Response by registered person detailing the actions taken: The domestic store has been fitted with shelving allowing for effective storage of cleaning equipment. A colour coded notice has been erected regarding the appropriate use of mops. The cleaning cupboard items are securely locked to ensure adherence to COSHH regulations.
Action required to ensure compliance with The Independent Healthcare Regulations (Northern Ireland) 2005	
Area for improvement 2 **Ref:** Regulation 19 **Stated:** First time **To be completed by:** 25 November 2021	The Registered Person shall ensure contracted workers, i.e. cleaners, have training commensurate to their role. Ref: 5.8
	Response by registered person detailing the actions taken: Cleaners have been provided with training commensurate to their role ie IPC/COSHH training.

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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111