Unannounced Inspection Report
11 to 13 March 2019
and
Announced Inspection
Report 4 September 2019

North West Independent Hospital

Type of Service: Independent Hospital – Acute Hospital
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Assurance, Challenge and Improvement in Health and Social Care

Membership of the Inspection Team

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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 hospital

North West Independent Hospital (NWIH) provides a wide range of surgical, medical and outpatient services for both adults and children. The hospital is registered for 35 overnight beds and 13 day case beds.

The hospital has three operating theatres, one of which has a Laminar Clean Air System (theatre 3), specifically designed for Orthopaedic and Ophthalmic Surgery and a dedicated endoscopy suite, an x-ray department and magnetic resonance imaging (MRI) scanning; a central sterile services department (CSSD) and a range of consulting rooms. The in-patient and day surgery accommodation comprises en-suite rooms situated on the ground floor of the premises.

3.0 Service details

Organisation/Registered Provider: North West Independent Hospital **Responsible Individual:** Mr Philip Stewart	**Registered Manager:** Ms Finola Carmichael
Person in charge at the time of inspection: Ms Finola Carmichael	**Date manager registered:** 6 April 2011
Categories of care: Independent Hospital (IH) Acute hospital (AH) (with overnight beds) Prescribed Technologies, Endoscopy PT(E) Prescribed Technologies, Laser PT(L) Private Doctor (PD)	**Number of registered places:** 35 in patient 13 day case places

Laser equipment

Manufacturer: Ceramoptec Biolitec

Model: Ceralas E

Serial Number: 4291G

Laser Class: 4

Laser protection advisor (LPA): Mr Philip Loan, Medical Physics, Belfast Health & Social Care Trust (BHSCT)

Laser protection supervisor (LPS): Mr Zola Mzimba

Medical support services: Mr Zola Mzimba

Clinical authorised users: Two named Consultant Surgeons

Non –clinical authorised users: Ms Laura Cave

Types of treatment provided: Endovenous closure using laser therapy

4.0 Inspection summary

We undertook an unannounced inspection to North West Independent Hospital (NWIH) over two days, commencing on Monday 11 March and Tuesday 12 March 2019. Following this inspection RQIA received further information and an announced follow up inspection to review the arrangements in respect of medical cover was undertaken on 4 September 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. RQIA's medical physics expert supported the inspection in respect of the laser operated within the hospital. Two health estate engineers from the Department of Health (DoH) supported the inspection of NWIHs endoscopy suite and arrangements for reprocessing of flexible endoscopes.

The multidisciplinary inspection team examined a number of aspects of the hospital, from front-line care and practices, to management and oversight of governance across the organisation. We met with various staff groups; spoke with several patients, observed care practice and reviewed relevant records and documentation used to support the governance and assurance systems.

Patients and their representatives informed us they were happy with their care and spoke positively 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 and to make informed choices.

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

We undertook a detailed review of the current arrangements for governance and managerial oversight within the hospital; we identified a number of areas of significant concern in relation to the overarching governance structure, medical governance arrangements and management of incidents/events.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	8	7

Eight areas for improvement were identified against the regulations, these related to:

- the arrangements in respect of clinical and organisational governance;
- the arrangements in respect of the medical advisory committee;
- management of venous thromboembolism (VTE);
- the management of incidents;
- regulation 26 unannounced quality monitoring visits;
- ensuring all authorised operators have undertaken training in accordance with RQIA training guidance;
- the need to undertake a review of staffing levels; and
- the arrangements in respect of medical cover.

Seven areas requiring improvement were identified against the standards, these related to:

- strengthening the arrangements in respect of clinical audits undertaken;
- strengthening infection prevention and control (IPC) practices;
- further strengthening practices in respect of Aseptic Non Touch Techniques (ANTT);
- ensuring that controlled drug registers are fully and accurately completed and a regular auditing process is in place;
- ensuring that cleaning schedules are completed and audited;
- ensuring that themes emerging from complaints analysis are shared with the MAC and other relevant governance committees and clinical teams; and
- ensuring the key audit findings issued by DoH Health Estates in relation to the premise's endoscopy decontamination equipment, facilities and processes are fully implemented.

On 13 March 2019, we provided feedback to Ms Finola Carmichael, Registered Manager (RM) and some members of the management team regarding the inspection findings. During this meeting, we discussed the hospital's strengths and the areas requiring improvement identified during our inspection. We noted that Mr Philip Stewart, Responsible Individual (RI) other members of the NWIH's Senior Medical Management Team (SMMT) were not in attendance at this feedback meeting.

We requested a further feedback meeting with Mr Stewart and members of the SMMT. The second feedback meeting took place on 27 March 2019, at which NWIH were represented by Mr Stewart, Ms Carmichael, the Chairman of the Medical Advisory Committee (MAC) and the Responsible Officer (RO) for NWIH. At this meeting, we highlighted the importance of the hospital's SMMT receiving and understanding key messages relating to good practices and areas for improvement identified during our inspection.

At both feedback sessions we discussed the actions which are required with the Quality Improvement Plan (QIP). The timescales for completion of these actions commence from the date of our inspection.

4.2 Enforcement taken following this inspection

As part of our inspection process we invited feedback from front-line staff. Following the inspection we received feedback from staff which identified a number of additional concerns, which were not raised by staff during the inspection. These concerns related to the current management arrangements, allegations of a culture of bullying and harassment and inadequate arrangements for medical cover in the hospital.

In response to concerns identified during and following our inspection, we invited Mr Philip Stewart, (Responsible Individual) and a representative from the SMMT to attend a serious concerns meeting in RQIA on 10 May 2019. At this meeting we discussed our concerns in relation to governance; medical governance; and notifiable events/incidents. We also discussed the additional concerns raised by staff following the inspection.

Mr Stewart attended the serious concerns meeting, where the required actions to address our concerns were agreed. These actions are described throughout this report. A follow-up unannounced inspection of NWIH is likely to be required to ensure improvements and compliance is achieved in the areas where we have highlighted particular concerns.

5.0 How we inspect

Prior to this inspection, we reviewed a range of information relevant to the establishment including the following records:

- notifiable events prior to and since the previous inspection;
- registration status of the establishment;
- written and verbal communication received since the previous inspection;
- the previous inspection reports; and
- QIPs returned following the previous inspections.

During our inspection, we spoke with patients and distributed questionnaires to patients. We did not receive any completed patient questionnaires following the inspection. We also invited staff to complete an electronic questionnaire during the inspection. Eighteen staff completed questionnaires which were analysed following the inspection. As discussed, feedback from front-line staff identified a number of concerns, in relation to current management arrangements, reduced staffing levels, poor staff morale, a culture of bullying, harassment and blame, poor communication and ineffective and unsupportive management. Additional information in this regard can be found in section 6.9 of this report.

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: Ms Carmichael (Registered Manager), medical staff, nursing staff, healthcare assistants, allied health professionals (AHPs), catering staff, cleaning staff, administration staff and the hospital's nominated estates and facilities manager.

We inspected Ward1, Ward 2, and the theatre department including the laser equipment, the outpatients department and the central sterile services department (CSSD).

During the inspection a sample of records were examined in relation to each of these 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 inspections dated 28 to 29 November 2017, 20 January 2017 and 19 January 2016 respectively

The previous inspection of the hospital was an announced care inspection undertaken on 28 and 29 November 2017, the previous premises inspection was undertaken on 20 January 2017 and the previous pharmacy inspection was undertaken on 19 January 2016. Following each of these inspections a QIP was completed and returned by Ms Carmichael, (Registered Manager) and approved by the relevant inspector.

6.2 Review of areas for improvement from the previous care (28 to 29 November 2017), premises (20 January 2017) and medicines management (20 January 2017) inspections

Areas for improvement from the last care inspection on 28 and 29 November 2017		
Action required to ensure compliance with The Minimum Care Standards for Independent Healthcare Establishments (2014)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 48.20 **Stated:** First time	The registered person should ensure that the LSO Medical Endotherme 1470 laser is not used until such times as the laser engineer provides confirmation that the machine has been serviced. Records of servicing should be retained in the North West Independent Hospital and be available for inspection.	**Met**
	Action taken as confirmed during the inspection: Records to evidence that the LSO Medical Endotherme 1470 laser had been serviced prior to the machine being used were retained in the laser safety file. A new laser has been installed following the previous inspection. A commissioning and installation report was in place in respect of the new laser. It was confirmed that the new laser is under manufacturer's warranty and a service level agreement in respect of the servicing of this laser is in place.	
Area for improvement 2 **Ref**: Standard 3.9 **Stated:** First time	The registered person should review the Northern Ireland Adult Safeguarding Partnership Training Strategy 2013 (revised 2016) to ensure that appointed safeguarding champions have undertaken the correct level of training. Training certificates should be retained and available for inspection.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff evidenced that two members of staff are designated safeguarding champions. Review of records evidenced that one of the identified staff members has completed appropriate training. The second staff member was scheduled to attend an appropriate course. However, the course was cancelled by the organisation providing the training. We were informed that the second staff member will be completing safeguarding champion training when available.	

Area for improvement 3 **Ref**: Standard 17.4 **Stated:** First time	The registered person should review the management of accidents/incidents to ensure that there is a consistent approach across all departments and to ensure that all accidents/incidents are collated in a central place to facilitate audit.	**Met**
	Action taken as confirmed during the inspection: A review of accident/incident records confirmed that the same arrangements are in place for documenting accidents/incidents across all departments. We identified three notifiable events that had not been submitted to RQIA. Additional information in this regard can be found in section 6.7 of this report. An area for improvement against the regulations has been made in respect of incident management and notifications.	

Areas for improvement from the last premises inspection on 20 January 2017		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 25 **Stated:** First time	The arrangements for carrying out the checks to the fire/smoke dampers and any other remaining issues from the action plan in the report for the fire risk assessment that was carried out on 04 November 2016 should be finalised and confirmed to RIQA.	**Met**
	Action taken as confirmed during the inspection: Visual inspections completed by site based operatives. Specialist engineers `VSS` are contracted to complete fire/smoke damper maintenance/test assurance works.	
Action required to ensure compliance with The Minimum Care Standards for Independent Healthcare Establishments (2014)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 24 **Stated:** First time	RQIA should be kept up to date with the programme of work to fit the free swing self-closing devices to the bedroom doors.	**Met**
	Action taken as confirmed during the inspection: Improvement works approximately 50% complete; work ongoing.	

Area for improvement 2 **Ref**: Standard 24 **Stated:** First time	A check should be carried out to the opening in the external wall in the steam plant room to ensure that the cavity in this external wall is sealed at this opening. Some minor fire stopping should be carried out to the ceiling in the UPS store for theatre 3. Completion of this work should be confirmed to RIQA.	**Met**
	Action taken as confirmed during the inspection: Repair works completed.	
Area for improvement 3 **Ref**: Standard 22 **Stated:** First time	A risk assessment should be carried out in relation to hot surfaces. The outcome of this risk assessment and proposed action should be confirmed to RQIA.	**Met**
	Action taken as confirmed during the inspection: Hot surfaces risk assessment completed.	
Area for improvement 4 **Ref**: Standard 22 **Stated:** First time	Completion of the issues identified for attention in the report for the audit of the medical gas pipeline systems that was completed by the Authorising Engineer (MGPS) in September 2016 should be confirmed to RQIA.	**Met**
	Action taken as confirmed during the inspection: Report issues remedied.	
Area for improvement 5 **Ref**: Standard 22 **Stated:** First time	Completion of the issues identified for attention in the report for the audit of the lift installations that was completed by the authorising engineer (Lifts) in September 2016 should be confirmed to RQIA.	**Met**
	Action taken as confirmed during the inspection: Lift installation report issues resolved. A thorough examinations inspection regime is implemented in accordance with Lifting Operations and Lifting Equipment Regulations (LOLER), Regulation 9.	
Area for improvement 6 **Ref**: Standard 20 & 22 **Stated:** First time	Completion of the issues identified for attention in the report for the audit of the ventilation installations carried out by the authorising engineer (Ventilation) in September 2016 should be confirmed to RQIA.	**Met**
	Action taken as confirmed during the inspection: Ventilation plant is maintained in compliance with HTM03-01.	

Area for improvement 7 **Ref**: Standard 9 & 22 **Stated:** First time	The outcome of the review in relation to the level of support and resources that are allocated to the estates team to ensure that these remain adequate to meet current and future demands should be confirmed to RQIA. This should also include the outcome of the considerations in relation to the ventilation installations in the older sections of the premises.	**Met**
	Action taken as confirmed during the inspection: The registered person has a maintenance manager and a multidisciplinary team of engineers/operatives employed to maintain the building services.	

Areas for improvement from the last medicines management inspection on 19 January 2016		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 15 **Stated:** First time	The registered person must ensure that all medicines which require refrigeration are stored in strict accordance with the manufacturers' instructions at all times.	**Met**
	Action taken as confirmed during the inspection: There were systems in place to ensure medicines were stored correctly. Maximum and minimum medicine refrigerator temperatures were closely monitored; there was evidence of the corrective action taken if temperatures deviated from the accepted range of 2^{o}C to 8^{o}C.	
Area for improvement 2 **Ref**: Regulation 15 **Stated:** First time	The registered person must investigate the discrepancies noted during the audit of a controlled drug in the ward and forward a written report of the investigation and any action taken to RQIA.	**Met**
	Action taken as confirmed during the inspection: A written report of the investigation outcomes was received by RQIA on 17 February 2016.	

Action required to ensure compliance with The Minimum Care Standards for Independent Healthcare Establishments (2014)		Validation of compliance
Area for improvement 1 **Ref**: Standard 26 **Stated:** First time	The medicine checklist on the emergency trolley should be reviewed and revised to ensure that it is up to date with respect to the strength and the required stock level of each emergency medicine and details of stock removal and replacement are recorded.	**Met**
	Action taken as confirmed during the inspection: The medicine checklist had been reviewed and stock was monitored on a monthly basis. Dates of expiry were clearly recorded and the monthly audit listed the stock which had been replaced.	
Area for improvement 2 **Ref**: Standard 27 **Stated:** First time	The record keeping in relation to controlled drugs stored in the ward should be monitored, to ensure that records of administration and transfer are fully documented on every occasion and the disposal record clearly indicates that controlled drugs have been denatured by two designated persons.	**Met**
	Action taken as confirmed during the inspection: We examined the ward controlled drug records and no further concerns were noted regarding the administration, transfer and disposal of controlled drugs.	
Area for improvement 3 **Ref**: Standard 28 **Stated:** First time	The necessary arrangements should be made to ensure that records of the receipt of medicines in the ward and in theatre are fully and accurately maintained on every occasion.	**Met**
	Action taken as confirmed during the inspection: Satisfactory systems were in place to record the receipt of medicines.	

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 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 the Mr Philip Stewart, Responsible Individual; Ms Finola Carmichael, Registered Manager; the chairman of the Medical Advisory Committee (MAC): the responsible officer (RO) for the hospital; the clinical governance and infection control lead; the decontamination services manager; the theatre manager and the ward manager.

We examined various aspects of the governance systems in place within the hospital and assessed that it was not functioning as intended, reliant on individuals, and had existed in its current form for a significant number of years. We were concerned that current governing systems depend too heavily on a small number of key personnel.

We noted that whilst there are a number of committees in place; including Clinical Governance, Infection Prevention and Control, Health and Safety, Risk Management, Clinical Audit and Evidence Based Care and Clinical Effectiveness; there was no evidence that these committees were meeting regularly and functioning as intended from mid-2018 onwards, which is particularly concerning.

We acknowledged that there have been staffing changes in the hospital; however, we reiterated that governance is not about individual staff but rather active management of a robust system of oversight and assurances that operates across the hospital. We noted that the roles and functions of the various committees were not clearly defined. We recommended that an urgent review of the hospital's governance structures should be undertaken to determine the role and function of each committee and to define which committees are needed to fulfil the governance requirements of the hospital.

We recommended that while not all the committees listed above may be necessary, the Clinical Governance Committee and the Risk Management Committee are two critically important parts of a working governance system. We explained that the Risk Management Committee should be closely linked with the Clinical Governance Committee, and the Clinical Governance Committee should be a sub-group and/or closely connected with the MAC.

Due to our concerns regarding governance arrangements expressed during and following the inspection, the following actions are required by NWIH:

- a rapid review of the hospital's governance structures should be undertaken to determine what committees are required in order to assure best practice;

- the role and responsibilities of each committee need to be clearly delineated to ensure there is no ambiguity with respect to who has overall responsibility for clinical governance, operational management and any other relevant roles within the hospital. All roles need to be clearly defined and specified;
- the clinical governance committee should either be a sub-group and or closely linked to the Medical Advisory Committee (MAC);
- the risk management committee should be closely linked with the clinical governance committee;
- the responsible individual should ensure that the identified governance lead is supported in their role by the MAC; clinical governance committee and key personnel with specialist roles within the hospital; and
- the responsible individual should ensure that an overarching cooperate risk register is developed with input from the clinical governance committee. The register must detail the measures in place to mitigate and control identified risks.

6.4.2 Medical governance and Medical Advisory Committee

In accordance with the Minimum Care Standards for Independent Healthcare Establishments (2014), the MAC should meet at least four times a year. We noted that the MAC had only met on one occasion during 2018. The minutes of the MAC meetings should provide evidence of both the discussions held during meetings and the specific actions taken/required as a result of these discussions. We could not find evidence of the MAC operating in this way or as part of a proactive system for oversight and assurance across the hospital.

We recommended regular meetings of the MAC should be the mechanism by which policies relating to clinical areas such as VTE and anti-microbial stewardship are developed and endorsed.

We reiterated that the function of a MAC is to advise and guide the hospital, in a proactive manner, and evidence the practice of live assurance and monitoring the quality of services/care throughout the hospital. We recommended that this issue requires urgent attention and a clear plan of action. We suggested that when the MAC meets next it should agree a standard agenda template as a guide for the meeting which should have a strong focus on governance, safety and assurance of good practice throughout the hospital.

Following the inspection we were informed that the chairperson of the MAC had resigned. On 5 June 2019 we were informed that a chair and deputy chair for the MAC had been appointed.

NWIH must undertake the following actions to ensure systems are implemented for good medical governance:

- ensure the MAC meets on a quarterly basis (as a minimum) and arrangements are in place for extraordinary meetings, as necessary;
- ensure the MAC reviews information in respect of adverse clinical incidents and is advising the hospital's senior management team on corrective action when/as necessary;
- ensure the MAC is assisting the senior management team to assure and evidence safe practice;
- ensure the MAC is providing the expertise to discuss and if necessary challenge practice of individual medical practitioners; and

- ensure minutes of MAC meetings accurately reflect discussions progressed, actions agreed and persons responsible for taking forward actions within agreed timescales.

6.4.3 Regulation 26 unannounced quality monitoring visits

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

We confirmed that Mr Stewart (Responsible Individual) undertakes a visit to the premises at least every six months in accordance with legislation. Reports of the unannounced monitoring visits were available for inspection. We noted the reports of the Regulation 26 visits did not include details of discussions with staff or patients. We recommended that in accordance with Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005, unannounced monitoring visit reports should contain evidence of his communication with staff and patients. We recommended that a communication section should be added to Mr Stewart's template to assure that there is appropriate evidence of this practice documented.

Mr Stewart should ensure that unannounced quality monitoring visits are undertaken in keeping with Regulation 26. The report generated as a result of these visits should clearly reflect the outcome of discussions with patients and staff. It should also comment on the governance and oversight arrangements reviewed in order to provide assurance on the quality and standard of services being provided.

6.4.4 Complaints management

We confirmed that the hospital has a complaints policy in place. We found this to be in line with the relevant legislation and DoH guidance on complaints handling. A copy of the complaints procedure is made available for patients/and or their representatives. Patients who spoke with us confirmed that they were aware of how to raise any concerns they may have. Discussion with staff demonstrated a good awareness of the processes for management of complaints.

We noted there have been 36 complaints in 2018 and nine complaints so far in 2019. The inspection team examined a range of complaints and noted that any complaints made were investigated and responded to appropriately. Records are kept of all complaints and included details of all communications with complainants; the result of any investigation; the outcome and any action taken. However, we found that themes emerging from complaints are not analysed appropriately with input from the MAC or Governance Committees, and are not currently influencing or informing improvement to practice or care delivered throughout the hospital.

Arrangements for the management of complaints within NWIH should be reviewed to ensure themes emerging from complaints analysis are shared with the MAC and other relevant governance committees. Actions taken to address themes should be recorded and learning from complaints should be disseminated across all staff groups.

6.4.5 Notifiable events/incidents

We reviewed the arrangements in respect of incident management. Review of incidents on file over the year prior to this inspection confirmed that 19 incidents were reported appropriately to RQIA. We felt that the management of medication incidents was strong and that this should continue in future. Three incidents however had not been reported to RQIA. These related to an intra-operative complication; a data breach; and a prescribing incident.

These three incidents were formally notified to RQIA during the inspection and following the inspection root cause analysis reports were submitted to RQIA. We discussed the serious nature of the three incidents and recommended that attention is needed to develop a robust incident investigation and reporting system. We suggested that ward sisters/charge nurses and their deputies are ideally placed to understand which incidents should be notified to RQIA.

We recommended that responsibility of reporting incidents should not fall on a single individual; but rather there needs to be a systemised approach for incident reporting. We highlighted that a robust system needs to be in place so that if an incident occurs at any time, for example at night or at weekends, it can be notified to RQIA in a timely manner (within 24 hours of occurrence). We recommended that the MAC are ideally placed to review the clinical incidents and related trends to allow for constructive peer challenge, oversight and assurance of the management of incidents.

NWIH must undertake the following actions to ensure systems are implemented for the management of notifiable events/incidents:

- review and strengthen the current system, which is currently dependent on two members of staff, to ensure the expertise is shared more widely, to build a sustainable approach across the hospital;
- review and strengthen the current system of incident investigation and management to ensure it is balanced between reviewing equipment, procedures and clinical practice;
- disseminate the learning, from incidents, across all staff groups;
- ensure that RQIA is informed of all incidents, in a timely manner, in keeping with RQIA's guidance document 'Statutory Notification of Incidents and Deaths';
- ensure that the information within the notification is sufficient in detail; and
- amend the current system for reporting to RQIA, via web portal, from one which is overseen by two people, to one that is more robust.

6.4.6 Practising privileges

We reviewed the arrangements relating to practising privileges; the role of the responsible officer (RO), and were happy to note the clear definition of roles and responsibilities for the RO for the hospital. There is currently one wholly private doctor working at NWIH, along with over 200 doctors who practice elsewhere and have their ROs in other locations/ organisations.

The inspection team found that the RO maintains strong linkages into the Regional RO Forum, there is evidence of his interaction and engagements with other ROs and he makes efforts to be up to date with all issues relevant to the wider group of doctors working in NWIH. We reiterated the value of this approach.

The inspection team found that hospital management maintained a robust oversight of arrangements relating to practising 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 for these doctors. We commended this practice and recommended that it continues into the future.

6.4.7 Risk registers

Currently there are risk registers for each department in NWIH but there is no evidence of an overarching corporate risk register for the hospital. We recommended that this needs to be addressed quickly as part of the hospital's review of its governance systems. The Clinical Governance Committee must provide input into the corporate risk register by defining the main risks for the hospital and clearly describing what measures are in place to mitigate and control said risks. The development of a risk register has been included in an area for improvement against the regulations in relation to clinical governance.

6.4.8 Quality assurance

We noted that several audits are currently ongoing in areas including IPC and medications. However, we could not evidence any escalations or action plans resulting from these audits.

We recognised that there is a large amount of work going into these audits, which could be streamlined significantly to ease the burden on staff participating in this work. We highlighted that an important aspect of auditing is escalation through the hospital's governance system and to the MAC, and dissemination of learning arising from the audit to the wards/theatres to influence care and practice. Currently neither the escalation nor the dissemination of learning could be evidenced as routinely occurring.

We recommended that the hospital needs to demonstrate through audit that best practice is implemented. This important area should be examined as part of the hospital's urgent review of its governance arrangements.

There was no evidence of audit outcomes being reported into the MAC meetings. We recommended that a core set of key quality indicators, which will be evidenced through audit, should be sent to the MAC, Clinical Governance and Risk Management Committees to allow for oversight and assurance of the implementation of good and best practice throughout NWIH.

Potential key quality indicators may include: IPC, VTE, medication audits, audit of return to theatres and transfers out to other acute hospitals.

NWIH must undertake the following actions to address the following matters with respect to audits:

- ensure that robust arrangements are established to escalate shortfalls identified during the audit process through the hospitals governance structures; and
- ensure that the audit of core key quality indicators is submitted and reviewed by the MAC and other key governance committees and evidence of actions taken to address shortfalls recorded.

During the serious concerns meeting on 10 May 2019, we were informed that the former clinical governance lead is now available on a consultancy basis to advise the registered manager and the current clinical governance manager on how to implement an effective audit programme. An individual from each department has been identified to be a link person. The link person will, in future, attend meetings and report analysed and collated information to the Clinical Performance Committee (CPC). The CPC will report to the MAC and the Registered Manager.

6.4.9 Management of operations

We found that there was a clear understanding of the organisational structure within the hospital. Staff were able to describe their roles and responsibilities and were aware of who to speak to if they had a concern.

Ms Carmichael is the nominated individual with overall responsibility for the day to day management of the NWIH.

We found that a range of policies and procedures were available for staff reference. We confirmed that policies and procedures were indexed, dated and systematically reviewed on at least a three yearly basis. Staff spoken with were aware of the policies and how to access them.

A system was also 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.

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

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

Observation of insurance documentation confirmed that current insurance policies were in place.

Areas of good practice

Areas of good practice were found in relation to the arrangements for managing practising privileges.

Areas for improvement Is the service well led?

We identified areas for improvement in relation to clinical and organisational governance; the role of the Medical Advisory Committee; Regulations 26 unannounced monitoring visits; management of notifiable events/incidents; management of complaints; the arrangements in respect of audit.

	Regulations	Standards
Areas for improvement	4	2

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 in the hospital and found there is a multi-professional team which includes consultant surgeons, consultant physicians, anaesthetists, nurses, radiographers, allied health professionals with specialist skills and experience to provide a range of hospital services including surgical services and specialist laboratory staff.

Review of the duty rotas confirmed that there was adequate staff in place to meet the assessed needs of the patients accommodated at the time of inspection. However, discussion with staff and review of documentation evidenced that staff that had specialist/leadership roles were unable to fully fulfil their responsibilities as they were delivering front line services. There was evidence that departmental meetings were not been undertaken routinely, staff were not being released to attend training and staff appraisals were overdue as a result of insufficient staffing levels and staff with specialist roles required to deliver front line services.

It was identified that two deputy ward sister posts were vacant and the NWIH were actively trying to recruit in respect of these posts. On discussion it was not clear to the inspection team the number of other staff vacancies, if any within the hospital.

NWIH must undertake the following actions to address the following matters with respect to staffing:

- staff who have specialist roles have protected time in order to fulfil the roles and responsibilities assigned to them;
- staff to undertake designated training, attend departmental meetings and complete an annual appraisal; and
- facilitate staff attendance at safety briefings.

Induction programme templates were in place relevant to specific roles within the hospital. A sample of three evidenced that induction programmes had been completed when new staff join the establishment.

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.

It was confirmed that a robust system was in place to review the professional indemnity status of all staff who require individual indemnity cover. Review of personnel files confirmed that medical practitioners had appropriate professional indemnity insurance in place and received the required annual appraisals.

6.5.2 Medical cover

It was confirmed that there is no resident medical officer (RMO) present in the hospital during the day, individual consultants anda are available should a medical emergency occur. It was suggested that there should be a nominated doctor to be the first point of call, should a patient become acutely unwell during working hours. This will ensure there is no potential for confusion as to who should be contacted should a patient's condition deteriorate. An internal daily rota to clearly identify the nominated doctor should be in place. It was agreed that a follow-up inspection would be undertaken to review the arrangements in respect of medical cover.

During the inspection (11-13 March 2019) no issues in respect of out of hour's medical cover were raised with the inspection team. However, following that inspection a review of the submitted staff questionnaires identified that a number of staff had concerns in respect of the management of the hospital and specifically the arrangements in respect of out of hour's medical cover. As a result of the concerns raised by staff Mr Philip Stewart (Responsible Individual) was invited to a serious concerns meeting at the offices of RQIA on 10 May 2019. At this meeting Mr Stewart stated that medical cover was available onsite at all times. Mr Stewart was informed that a follow-up inspection to review the arrangements in respect of medical cover would be undertaken.

NWIH must undertake the following actions to address the following matters with respect to medical cover:

- there is a nominated doctor onsite providing medical cover at all times;
- the medical cover rota is displayed in all clinical areas;
- the roles and responsibilities of staff providing medical cover are clearly defined;
- that staff providing medical cover undertake a handover at shift change;
- that staff providing medical cover have access to advice and support from consultants; and
- that the medical cover rota takes into account the needs of the patient group accommodated within the hospital, with particular attention being paid to children and young people.

Further information in regards to the staff concerns in respect of the management of the hospital can be found in Section 6.9 on pages 34 and 35 of this report.

6.5.3 Follow-up inspection to review the arrangements in respect of medical cover on 4 September 2019

We confirmed that there is an identified medical practitioner onsite at all times providing medical cover. The medical practitioner providing cover during the day would be one of the consultant anaesthetists scheduled to operate that day. We were informed on the occasion when only one consultant anaesthetist is working in the hospital, an additional medical practitioner from the night list would be booked to provide day cover.

In addition, a number of senior nursing staff have completed additional training and are identified emergency responders. We observed the emergency responder rota on display in the wards and outpatients department.

We could not see the emergency responder's rota on display in the theatre department. We recommended that the emergency responders should be clearly identified in the theatre allocation book.

We were informed that the NWIH is actively trying to recruit two resident medical officers (RMOs) to work opposite each other to provide medical cover during the day.

We were informed that some consultants will meet with the medical practitioner providing night cover and introduce them to their patients before they leave for the day. There is no formal arrangement in place in this regard and this occurs at the discretion of each individual consultant.

We noted that eight medical practitioners provide out of hours medical cover. The NWIH endeavours to agree the out of hour's rota one month in advance. The rota is however a working document and is often subject to change. The out of hour's rota was observed to be on display in the ward. We were informed that where a paediatric patient is accommodated overnight the medical practitioner providing out of hours medical cover is always a paediatric anaesthetist. We evidenced this on review of the out of hour's rotas. We were informed that there is no definitive start time for the out of hour's medical practitioner; however the expectation is they start between 17:00 and 18:00 hours. Should they start their shift at a later time, the consultant anaesthetist or another identified medical practitioner providing cover during the day remains in the hospital until they arrive. We noted that the out of hour's emergency rota only included the name of the medical practitioner. We recommended the rota should clearly identify the name of the medical practitioner and the times they provided cover.

We were informed that there is no formal medical handover between medical practitioners at the commencement of their shift. The medical practitioner providing cover during the night receives a handover from nursing staff on the ward and attends the nursing handover at shift change. We were informed that there is no record of this handover. We recommended that a formal medical handover process should be in place and documented, with records retained.

We were informed that a model job description and specification has been developed for the medical practitioners who provide medical cover. However, this was in draft form and has not been shared with the medical practitioners. We recommended that the Medical Advisory Committee should review and ratify this job description.

We were informed that should the medical practitioner providing night cover need advice or support they would contact the patients consultant. There is no formal on call consultant anaesthetist. An area for improvement against the regulations has been made to review the arrangements in respect of medical cover.

6.5.4 Recruitment and selection

We reviewed the arrangements in respect of the recruitment of staff. A number of staff had been recruited since the previous inspection. A review of a random sample of three personnel files of newly recruited staff evidenced that all the relevant information had been sought and retained.

NWIH also employs a number of private doctors. A review of one personnel file of a private doctor provided evidence 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.

We confirmed that each private doctor has an appointed responsible officer (RO).

6.5.5 Surgical services

We reviewed the arrangements in respect of the provision of surgical services. We noted strong practice in theatres throughout the inspection.

The inspection team found there was a delay in the signing of the surgical register by the Scrub Nurse in theatre. We recommended that the register should be signed on a daily basis, the day of the surgical procedure or the next day at the latest. The theatre manager confirmed that it was difficult to get the surgical register signed on the day of surgery as the sheets are collated by an administrator, and it can take a number of days for the typed register to be available to be signed. Therefore, it was suggested that as an interim arrangement scrub nurses should sign the operating log in theatres on the day of the surgical procedure, so that they have a reference point to assure themselves of the work completed in theatre each day. They could then sign the formal surgical register at a later point in time, informed by their daily logs which will already be signed.

We felt that the pre-operation assessments were carried out well. They were completed in advance of each patient's surgery and any queries were raised to the consultant anaesthetist if necessary.

We were informed that when a patient is not undergoing major surgery and particular medical conditions apply, the patient is asked to contact NWIH and a pro-forma is completed by telephone. As above, any queries from staff in relation to these pro-formas and assessments are brought to the anaesthetist's attention.

We noted guidance in place regarding the suitability of patients undergoing surgery at NWIH, and the evidence that this guidance is adhered to appropriately.

We observed guidelines in place for patients discharged from theatre (recovery) back to the ward, including a check from the anaesthetist on the final patient leaving recovery each day.

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 e.g. admission and discharge arrangements, wound management and infection prevention and control.

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 theatre manager, the consultant surgeon and booking office staff. 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 level of sedation used.

Review of the patient care records and discussion with staff and patients confirmed that the Anaesthetist who administers the anaesthetic visits the patient prior to surgery to:

- assess their general medical fitness;
- review their medication;
- explain the type of anaesthetic to be used; and
- discuss options for post-operative pain relief.

Discussion with staff and patients confirmed that the consultant surgeon meets with the patient prior to the operation to discuss the procedure and obtain informed consent.

There is an identified member of nursing staff, with theatre experience, in charge of the operating theatre at all times. A permanent record is retained of the name of nurse in charge of each theatre.

The Anaesthetist is present throughout the operation and is available onsite until the patient has recovered from the immediate effects of the anaesthetic.

On discussion staff confirmed that the surgical checklist based on the World Health Organisation (WHO) model is used in the hospital. Completion of the surgical checklists is audited as part of the hospitals clinical governance systems. Review of the audits confirmed that a high compliance rate is achieved.

The following areas of theatre practice were discussed with theatre staff:

- intra-operative fluid management including intra-cavity fluid management;
- procedure for massive blood loss;
- the cleaning of theatres to include deep cleaning;
- transfer of unwell patients to NHS hospitals, if required;
- servicing and maintenance of theatre equipment;
- completion of surgical registers; and

- participation in the national joint registry.

Discussion with staff confirmed that patients are observed during surgery and in the recovery room on a one to one basis by staff trained in anaesthetics and resuscitation.

The hospital has discharge criteria in place from theatre recovery to the ward area for inpatients and day patients.

We found gaps in the controlled drugs records in the theatres. This is discussed further in the medicines management Section of the report under Section 6.5.11 on pages 26 and 27.

6.5.6 Central Sterile Servicing Department (CSSD)/endoscopy arrangements

In conjunction with two health estate engineers from the Department of Health (DoH) we reviewed the CSSD and the arrangements in respect of the decontamination of endoscopes. The DoH engineers found that the decontamination facility was well manged and the processes witnessed provided an effective standard of decontamination of flexible endoscopes.

A number of positive themes were identified by the DoH engineers as follows:

- a good team present onsite;
- a good layout and design of premises;
- good practice evidenced throughout the inspection; and
- NWIH is ISO accredited from June 2018 (which will last for three years).

One area highlighted by DoH engineers was the definition of roles and responsibilities for members of the CSSD and endoscopy team. This is to ensure that NWIH complies with the relevant Health Technical Memoranda (HTM). It is recognised that in a small department this represents a challenge. The head of the CSSD department acknowledged after his conversation with DoH engineers, that he must step down from some roles within the team where there is a potential conflict of interest with other roles for which he is responsible.

The NWIH must fully implement the key audit findings issued by DoH Health Estates in relation to the premise's endoscopy decontamination equipment, facilities and processes.

6.5.7 Outpatients Department

We reviewed the arrangements in respect of the outpatient departments. We found robust management of the outpatients systems in the hospital, in particular the retention of patient notes on site at NWIH for those patients seen at outpatient clinics in the hospital.

6.5.8 Wards

We observed interactions between patients and staff on the front line; we found these interactions were caring and responsive to patients' needs. We front line staff to be dedicated to deliver high quality care, including their prompt response time to patient call bells.

We felt that pain management was carried out well, across a range of perspectives; patient views, medication used, as well as the documentation of pain management.

Patient privacy and dignity was well maintained, both in the ward and theatre settings.

A number of randomly selected patient records were reviewed. In the main care records were completed to a high standard, using a core care plan with individualised summaries for each patient. This high standard of record keeping was also reflected in the end of bed records, Visual Infusion Phlebitis (VIP) charts and Early Warning Score (EWS) charts.

One patient was on IV fluids during the inspection; we noted that the fluid management was well done, with good recording and documentation.

We noted that in relation to risk assessment and management of continence, skin pressure and pressure ulcers, despite having a low risk patient group, the risks were well accounted for and appeared well managed.

We reviewed the completion of venous thromboembolism (VTE) assessments for nine patients. Seven patient files showed the assessment was well completed and documented. For the remaining two patient files, there was a lack of documentation of the VTE assessment; however the assessment for each of these two patients was ongoing. We recognise that this was due to the nature of the service as patients will be continually assessed during their episode of care.

We found that the hospital have adopted the Western Health and Social Care Trust (WHSCT) VTE policy, which indicates that patients who are under general anaesthetic for less than 45 minutes do not require VTE risk assessments.

VTE risk assessments are not carried out for all patients. We recommended that the NWIH need to assure and evidence that all patients requiring VTE assessment are receiving these and that this is appropriately documented. We recommended that all surgical patients must have a VTE risk assessment in keeping with the National Institute for Health Care Excellence (NICE). We identified the need for evidence to show that staff are adhering to the policy that is in place, with responsibility for oversight of adherence to the policy resting with the MAC and the hospital's governance structures.

NWIH must undertake the following matters with respect to the management of venous thromboembolism (VTE):

- review the current VTE management policy and ensure that it is in keeping with NICE guideline [NG89];
- ensure that the MAC contributes to and approves the updated VTE policy;
- ensure that VTE risk assessments are undertaken and documented in respect of all patients admitted for surgical procedures; and
- develop a rolling audit programme to provide assurance that the VTE policy is being adhered to.

6.5.9 Laser safety

It was confirmed that a new laser was installed during July 2018. The LSO Medical Endotherme 1470 laser that was onsite during the previous care inspection is no longer operational. The details of the new laser are detailed in section 3.0 of this report.

We reviewed the arrangements in respect of the use of the laser machine. A laser safety file was in place which contained all of the relevant information in relation to the laser equipment. It was noted that current and historic information was retained within the laser safety file. It was suggested that the laser safety file is reviewed; historic documents should be archived to ensure that staff can easily access the most up to date version of documents.

There was written confirmation of the appointment and duties of a certified Laser Protection Advisor (LPA) which is reviewed on an annual basis. The service level agreement between the establishment and the LPA was reviewed and this expires on 31 March 2020.

Up to date Local Rules are in place which have been developed by the LPA. The Local Rules contained the relevant information pertaining to the laser equipment being used.

The establishment's LPA completed a risk assessment of the premises following the installation of the new Ceramoptec Biolitec Ceralas E laser machine during July 2018 and no recommendations were made.

A list of clinical and non-clinical authorised operators is maintained and authorised operators have signed to state that they have read and understood the local rules and medical treatment protocols.

We reviewed the training records for all authorised operators and support staff. We noted that authorised operators had appropriate core knowledge and safe use and application training. However we could not find evidence of other mandatory training such as fire safety, infection prevention and control (IPC), safeguarding and basic life support. NWIH must ensure that records are retained to evidence that all clinical authorised operators using the laser have completed training in keeping with RQIA training guidance for cosmetic laser services.

When the laser equipment is in use, the safety of all persons in the controlled area is the responsibility of the Laser Protection Supervisor (LPS). Arrangements are in place for another clinical authorised operator to deputise for the LPS in their absence, who is suitably skilled to fulfil the role.

The laser surgical procedures are delivered in the endoscopy room within the hospital's theatre suite.

The environment in which the laser equipment is used was found to be safe and controlled to protect other persons while treatment is in progress. The controlled area is clearly defined and not used for other purposes, or as access to areas, when laser surgical procedures are being carried out.

The door to the endoscopy room is locked when the laser equipment is in use but can be opened from the outside in the event of an emergency.

The laser equipment is operated using a specific individualised key. Arrangements are in place for the safe custody of the laser key when not in use.

Laser safety warning signs are displayed when the laser equipment is in use and removed when not in use.

Protective eyewear was available. The Local Rules specified that the laser eyewear should have a minimum rating of (EN207) of 1400 D LB3. The document also describes the eyewear as '1450-1650 DI LB2'. The protective eyewear in place was compared with the photograph of protective eyewear within the Local Rules and this confirmed that they were the same. However, as the Local Rules makes reference to D LB3 and DI LB2, NWIH should confirm with the appointed LPA if the reference to D LB3 is correct or not.

The establishment has a laser surgical register which is completed every time the equipment is operated and includes:

- the name of the person treated;
- the date;
- the operator;
- the treatment given;
- the precise exposure; and
- any accident or adverse incident.

A review of the laser surgical register during the inspection found it to be comprehensively completed.

As discussed, the Ceramoptec Biolitec Ceralas E laser machine was installed during July 2018. This machine is still under manufacturer's warranty and review of documentation evidenced that a service level agreement is in place. The Ceramoptec Biolitec Ceralas E laser machine is due to be serviced during July 2019.

6.5.10 Safeguarding

We reviewed arrangements for safeguarding of children and adults in accordance with the current regional guidelines. We confirmed that policies and procedures were in place in relation to safeguarding and protection of adults and children at risk of harm. We spoke to staff who 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 record matrix demonstrated that all relevant staff had received training in safeguarding children and adults.

We found that a whistleblowing/raising concerns policy was available which provides guidance to help staff make a protected disclosure should they need or wish to. Staff confirmed that they knew who to contact should they have concerns or needed to discuss a whistleblowing matter.

6.5.11 Medicines management

We reviewed the arrangements in place for the management of medicines with in the hospital which we found to be largely satisfactory.

A Pharmacist is available two days per week. Medicines were ordered twice weekly by designated staff. Separate requisition/receipt records were in use for general medicines and controlled drugs.

The admission and discharge process for patients was examined. Staff informed us that all patients were encouraged to bring a copy of their medicine regimes and medicines to the hospital. There was evidence that this occurred. A record of all incoming medicines and medicines transferred with the patient at discharge was maintained. This process involved two registered nurses to ensure accuracy. This good practice was acknowledged. We were also informed that patients were provided with information regarding any medicines prescribed within the hospital both during their stay and as an integral part of the discharge process.

Kardexes were well maintained, including completion of patients' weight and allergy status. In relation to medicines administration, the records indicated medicines were being administered as prescribed; and in cases where medicines had been omitted, the reason for this had been documented.

In relation to the disposal of medicines on the ward, the disposal record included several entries stating the reason as "fell on floor". We explored this with staff to establish the administration process and a reasonable explanation was provided. This record book should be included in the internal audit processes and trends identified and followed up.

We examined the management of controlled drugs. Controlled drugs were stored and administered safely. Systems were in place to check stocks at each change of shift. On the ward these checks included other controlled drugs which do not require storage in a controlled drug cabinet. In theatre and recovery, in addition to the lock, a tamper evident seal was affixed to the controlled drug cupboards and a new seal placed after each opening, as an additional security measure. These areas of good practice were acknowledged. We spot checked a number of controlled drugs and no discrepancies were identified. However, in relation to controlled drug record keeping, we observed cancelled entries in the controlled drug record books, due to recording errors, and overwriting. Also in theatre, there were a number of incomplete entries regarding the times of supply, administration or disposal and the actual quantity disposed. Some of the handwriting was difficult to read.

A list of specimen signatures of staff responsible for signing the controlled drug record book was not in place. This was being addressed at the inspection. Previously, a three monthly controlled drug audit had been completed; there was no evidence that this was current practice. The need for regular auditing and monitoring of controlled drugs was discussed. The NWIH should ensure that controlled drug registers are fully and accurately completed and a regular auditing process is in place. Actions taken to address deficits identified as a result of audits should be recorded and learning disseminated to appropriate staff.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Medicine refrigerators and the contents of emergency trolleys were checked each day.

There were arrangements in place to audit patients' medicines and patients' medicine records on a monthly basis. We were provided with the audit outcomes, most of these were satisfactory and some discrepancies were listed. However, it was not clear how the learning was shared with staff to prevent recurrence.

We discussed incident management. One medicine incident was highlighted and we were informed of the investigation taking place and change in paperwork as a result of the incident; however, this had not been reported to RQIA. Some errors noted in the monthly medicine audits had not been reported to RQIA. As previously stated in Section 6.4.5 on page 16, an area for improvement has been made in regards to notifiable events/incidents.

6.5.12 Resuscitation and management of medical emergencies

We reviewed the arrangements in respect of the management of medical emergencies. The policy and procedures for the management of medical emergencies reflected best practice guidance. Staff demonstrated a good understanding of the actions to be taken in the event of a medical emergency, and were aware of the location of medical emergency medicines and equipment.

In the main, the resuscitation trolleys were observed to be well organised and well stocked. Emergency medicines are checked by the hospital pharmacist who then seals and tags the emergency medicine boxes. A system was in place to ensure that emergency medicines and equipment do not exceed their expiry date and identified individuals had responsibility for checking emergency medicines and equipment.

We observed that the emergency trolley in the recovery unit of theatres has boxes of medication not stored in the drawer with a tamper-proof seal. The seals on these boxes had been broken and taped down again, rather than replaced. In contrast, the emergency trolley located in the wards had boxes of medication stored in the drawer with the tamper-proof seal, so it would be immediately evident if the drawer was opened. We recommended that the boxes on the emergency trolley in recovery are re-examined and if necessary, tagged with new tamper-proof seals.

A review of training records and discussion with staff confirmed that staff had undertaken life support training and updates. A minimum of one staff member with advanced life support training is on duty at all times. Staff involved in the provision of paediatric care had paediatric life support training and updates, and when children are admitted for treatment there is at least one staff member on duty who is trained in paediatric advanced life support.

The arrangements for patients with a “Do Not Resuscitate” (DNAR) order were discussed and it was confirmed that patients who have a DNR order would not meet the criteria for admission to the hospital.

6.5.13 Infection prevention control (IPC)

We reviewed the arrangements in respect of IPC. The hospital environment and patients’ rooms were clean, which was welcomed from an infection prevention and control viewpoint. However, we noted that while there are schedules in place for environmental cleaning and the hospital environment is clean, the cleaning schedules are not currently being appropriately completed. NWIH should ensure that cleaning schedules are fully completed to provide evidence and assurance that the environmental cleaning is correctly undertaken.

The above learning is also relevant to equipment cleaning schedules; we found that for the most part, equipment was clean and well maintained. However dust was observed to be present on the resuscitation trolley.

We found that some elements of IPC and Aseptic Non-Touch Technique (ANTT) are not appropriately implemented by all members of ward staff. The importance of ensuring competency assessments are undertaken to evidence implementation of best practice following the planned training was discussed. The Clinical Governance and Infection Control Lead confirmed that plans for training which will include a tutorial video and reading of the policies have been developed. Following training practical aspects of the training will be assessed and competency assessment for individual staff undertaken. It was recognised that the NWIH has already given some thought to the further development of staff training in this area.

The NWIH should ensure the following matters with respect to Aseptic Non Touch Techniques (ANTT) used during clinical practices are addressed:

- further develop the training programme and ensure it is delivered to appropriate staff;
- ensure staff who have completed ANTT training are competency assessed; and
- develop a rolling audit programme to provide assurance that staff are adhering to best practice following training.

There were clear lines of accountability for infection prevention and control (IPC). The establishment has a designated IPC lead nurse. There was a range of information for patients and staff regarding hand washing techniques.

Arrangements were in place to ensure the decontamination of equipment and reusable medical devices in line with manufacturer's instructions and current best practice. Staff confirmed single use equipment is used where possible.

Staff have been provided with IPC training commensurate with their role. Discussion with staff confirmed they had a good knowledge and understanding of IPC measures.

A range of IPC audits have been carried out including:

- environmental;
- hand hygiene; and
- surgical site infection.

The results of these audits were displayed on a dedicated IPC noticeboard located in a corridor in the in-patient area. However, we could not evidence any escalations or action plans resulting from these audits.

We acknowledged that there is a large amount of work going into these audits, which could be streamlined significantly to ease the burden on staff participating in this work. We reinforced that an important aspect of auditing is escalation through the hospital's governance system and to the Medical Advisory Committee (MAC), and dissemination of learning arising from the audit to the wards/theatres to influence care and practice. Currently neither the escalation nor the dissemination of learning can be evidenced as occurring. As previously stated in section 6.4.8 on page 17, an area for improvement has been made in regards to audit.

Patients spoken with confirmed staff are diligent in carrying out hand washing when delivering care. Patients also confirmed they were screened for infections such as Methicillin-resistant staphylococcus aureus (MRSA) prior to admission to the hospital for surgery.

There were a range of IPC policies and procedures in place which were located within an IPC manual.

There was no evidence of a specific hospital antimicrobial medicines prescribing policy. There was no system for carrying out formal audits regarding the use of antimicrobial medicines within the hospital. It was recommended that this area of medicines management should be reviewed to ensure robust systems were in place in relation to prescribing, administering and governance of antimicrobial medicines. A review of infection prevention and control arrangements indicated that practice would be further strengthened with the development of an anti-microbial/antibiotic stewardship policy.

The NWIH shall strengthen infection prevention and control (IPC) procedures as follows:

- ensure that the NWIH develops an anti-microbial/antibiotic stewardship policy in keeping with NICE guideline [NG15];
- ensure the MAC liaises with consultant surgeons and contributes to the development of the policy;
- ensure the policy clearly specifies the prophylaxis medications that can be prescribed by surgeons; and
- ensure that a rolling audit programme is developed to provide assurance that the policy is being adhered to.

6.5.14 Environment

We found that NWIH estates team was well managed and that a new water safety group has been established in the hospital. We welcomed the establishment of this new group, as it brings together estates, IPC, housekeeping, CSSD and surgical services staff, in addition to actively seeking microbiology input. The group is scheduled to meet twice a year; we recommended that the frequency of meetings may need increased, depending upon the volume of work requiring to be progressed by the group.

We recognise that the NWIH has been taken a proactive approach to water safety and recommended that the hospital continue to ensure the safety of the environment in which patients receive care.

Though a number of confirmations were outstanding for items relating to maintenance of the hospital estate, which we will need to be submitted to RQIA and reviewed, there were no major concerns raised in these areas. Following the inspection all outstanding documents in relation to estates matters were submitted to RQIA.

Areas of good practice: Is care safe?

There were examples of good practice found in relation to staff recruitment, induction, training, safeguarding, management of medical emergencies, decontamination procedures, and the environment.

Areas for improvement: Is care safe?

We identified areas for improvement in relation to the further development of Venous Thromboembolism (VTE) policy, clinical authorised operators training records; staffing levels, medical cover; infection prevention and control policies; Aseptic Non Touch Techniques (ANTT); cleaning schedules; controlled drug registers and Central Sterile Servicing Department (CSSD).

	Regulations	Standards
Areas for improvement	4	5

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 visited the two inpatient wards in the hospital to understand the effectiveness of care from the time of referral to the hospital through to discharge. Many areas of good practice were identified with respect to the care delivered. We spoke to patients who were complimentary of the quality of care and services received. We observed staff on both wards engaging positively with patients.

Patients confirmed they were provided with a comprehensive information pack prior to their admission which outlines any pre-operative requirements and the arrangements for their stay in the hospital. Copies of the patient guide are made available to all patients following admission.

We reviewed nine patient records and found that they contained comprehensive information relating to pre-operative, peri-operative and post-operative care which clearly outlined the patient pathway and included the following:

- patient personal information;
- holistic assessments;
- pre-operative care plans;
- pre-operative checks;
- signed consent forms;
- surgical safety checklist;
- operation notes;
- anaesthetic notes;
- medical notes;
- intra-operative care plans;
- recovery care plans;
- post-operative care plans;
- multidisciplinary notes;
- daily statement of the patient's condition; and
- discharge plan.

As discussed above, care records were completed to a high standard, pain and IV fluid management was well documented, risk assessments pertaining to management of continence, skin pressure and pressure ulcers were well managed. However, as discussed the arrangements in respect of VTE risk assessments could be further strengthened. An area for improvements against the regulations has been made in this regard.

Patients who spoke with us confirmed that they had received written information regarding their treatment and had the opportunity to meet with their surgeon prior to going to theatre to discuss the nature of the surgery, the risks, complications and expected outcomes before signing the consent form. The consent forms reviewed by us were signed by the consultant surgeon and the patient.

6.6.2 Records

Systems were in place to audit the patient care records as outlined in the establishment's quality assurance programme. A number of audits relating to patient care records were reviewed and an excellent compliance rate was noted.

We confirmed that staff were aware of the General Data Protection Regulations that came into effect during May 2018 and that they are compliant with this legislation.

The establishment is registered with the Information Commissioner's Office (ICO).

Staff demonstrated they had a good knowledge of effective records management procedures. The establishment 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.

The establishment also has a policy and procedure in place for clinical record keeping in relation to patient treatment and care which complies with (GMC) guidance and Good Medical Practice and other professional bodies' guidance.

The management of records within the establishment was found to be in line with legislation and best practice.

6.6.3 Discharge planning

We reviewed discharge planning arrangements and found that there was full engagement with patients and/or their representatives. Multi-disciplinary involvement in discharge planning was evident during our discussions with staff. We found good systems for ensuring that agreed discharge arrangements are recorded and co-ordinated and that all required services are involved in the patient's ongoing care and treatment.

We were told that a discharge summary and plan is completed prior to the patient leaving the hospital. A letter is provided to the patient's General Practitioner (GP), which outlines the care and treatment provided.

6.6.4 Nutrition and hydration

We reviewed arrangements to ensure that patients had access to appropriate food and water and their nutritional needs were met. We found that nursing staff are responsible for the co-ordination of mealtimes and recording of food and fluid intake. We spoke with patients who gave positive feedback in relation to the availability of food and fluids, menu choices and the quality of food in the hospital.

Nursing and catering staff demonstrated a good knowledge of special diets and processes in place to ensure patients are provided with food and fluids suited to their specific dietary needs. Staff described how information relating to patients diets is shared, including specialised diets and food allergies. We concluded that the meal service was of an excellent standard in terms of the coordination of the service, assistance of patients, as well as the variety of the food offered, and this was a strong area for NWIH.

Areas of good practice

We found examples of good practice in relation to the delivery of care; pain management; meals and mealtimes; communication between patients and staff; admission and discharge planning and the completion of clinical records.

Areas for improvement: Is care effective?

No areas for improvement were identified during the inspection.

	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 spoke with patients, looked at care records, observed care 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 and patients throughout our inspection. Staff treated patients with compassion, dignity and respect, introducing themselves and explaining procedures to patients in a kind and caring manner. A call bell system was in place for patients to attract the attention of staff, patients confirmed it was easy to use and that staff responded and attended to their needs in a timely way.

Staff wore badges with their name and profession/designation clearly visible and legible. Patients reported that staff spoke with them at the beginning of each shift and that they knew who to contact should they require any assistance or information.

6.7.2 Breaking bad news

The hospital has a policy and procedure for delivering bad news to patients and/or their representatives which is accordance with the breaking bad news regional guidelines.

The hospital retains a copy of the Breaking Bad News Regional Guidelines 2003 and this is accessible to staff.

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 and procedure.

Where bad news is shared with others, staff confirmed that consent must be obtained from the patient and is 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.

With the patient's consent, information will be shared with the patient's general practitioner 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 through speaking with patients, staff and reviewing relevant documentation. We found this to be an integral part of the service delivered in the hospital. In-patients, day patients, parents and children are offered an opportunity to provide feedback on their care through completion of a questionnaire. A child friendly questionnaire is also available which uses pictures.

We found that findings and results of questionnaires was available to patients was collated monthly and shared with all heads of departments, the Medical Advisory Committee and discussed at staff meetings. These reports are analysed to identify trends and patterns and action plans were generated, when necessary. Monthly patient satisfaction reports were visible on patient notice boards.

Areas of good practice: Is care compassionate?

There were examples of good practice found throughout the inspection in relation to maintaining patient confidentiality, ensuring the core values of privacy and dignity were upheld and providing the relevant information to allow patients to make informed choices.

Areas for improvement: Is care compassionate?

No areas for improvement were identified during the inspection.

	Regulations	Standards
Areas for improvement	0	0

6.9 Patient and staff views

During our inspection, we spoke with patients and distributed questionnaires to patients for completion and return to RQIA. We did not receive any completed patient questionnaires following the inspection. We found that patient feedback across multiple areas of the hospital, for all aspects of care was very good. Patients felt safe, secure and well-informed about the care they were receiving. Patients indicated that staff were caring and responsive to their needs. Patients indicated that they were treated with dignity and respect and that symptoms of pain were well managed.

Eighteen staff completed the questionnaire and two staff skipped all questions. Staff responses for safe, effective and compassionate care and if the service is well led are indicated in the table below.

	Very Satisfied	Satisfied	Undecided	Unsatisfied	Very Unsatisfied
Safe	1	4	2	5	4
Effective	2	7	2	3	2
Compassionate	5	3	1	3	4
Well led	2	7	2	3	2

Slightly more respondents indicated that they felt the service was well led. Many respondents indicated that they felt care was not safe. A small majority of respondents did not feel care was effective. When asked if care was compassionate we received a mixed response.

Comments in staff questionnaires identified a number of concerns, which were not raised during the inspection. These concerns related to the current management arrangements, a culture of bullying and harassment and inadequate arrangements in respect of medical cover.

As a result of the issues identified during the inspection and the concerns raised by frontline staff in the feedback questionnaires, Mr Philip Stewart, Responsible Individual was invited to a serious concerns meeting at the offices of RQIA on 10 May 2019.

During the meeting Mr Stewart informed us, that in his view, there is a friendly atmosphere in the hospital and that he has never been made aware of any complaints in regards to bullying or harassment and that he has full confidence in the current management. Mr Stewart confirmed that he will visit the hospital site more frequently and that he will arrange for the human resources (HR) manager to undertake a robust engagement exercise to better understand the experiences of staff and managers within the hospital.

We informed Mr Stewart that he must investigate the reports of bullying and harassment and lack of confidence in management and provide a report detailing the outcomes of this investigation and any identified actions for improvement to RQIA on or before the 5 July 2019. On 5 July 2019 Mr Stewart submitted to RQIA, evidence that an extensive employee satisfaction survey had been undertaken. In total 62 staff out off 142 employees submitted responses. Although staff responses indicated some areas for improvement, in general responses were positive with 83% of staff indicating they would recommend NWIH as an employer.

As discussed in sections 6.4 and 6.5 of this report a number of areas for improvement have been made in relation to the arrangements in respect of medical cover and governance and oversight arrangements.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Stewart, (Responsible Individual), Ms Carmichael, (Registered Manager) the Chairman of the Medical Advisory Committee (MAC) and the Responsible Officer (RO) for NWIH on two occasions during feedback delivered on 13 and 27 March 2019. They were also discussed during our serious concerns meeting held on 10 May 2019. The timescales for the implementation of these improvements commence from the date of this 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 including possible prosecution for offences. 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

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).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas 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 Independent Health Care Regulations (Northern Ireland) 2005 and The Minimum Care Standards for Independent Healthcare Establishments (2014)	
	Clinical and Organisational Governance
Area for improvement 1 **Ref:** Regulation 17 **Stated:** First time **To be completed by:** 5 June 2019	The registered persons shall address the following matters with respect to the governance arrangements within the hospital: • a rapid review of the hospital's governance structures should be undertaken to determine what committees are required in order to assure best practice; • the role and responsibilities of each committee need to be clearly delineated to ensure there is no ambiguity with respect to who has overall responsibility for clinical governance, operational management and any other relevant roles within the hospital. All roles need to be clearly defined and specified; • the clinical governance committee should either be a sub-group and or closely linked to the Medical Advisory Committee (MAC); • the risk management committee should be closely linked with the clinical governance committee; • ensure that the identified governance lead is supported in their role by the MAC; clinical governance committee and key personnel with specialist roles within the hospital; and • ensure that an overarching cooperate risk register is developed with input from the clinical governance committee. The register must detail the measures in place to mitigate and control identified risks. Ref: 6.4.1
	Response by registered person detailing the actions taken: - A rapid review of NWIH's governance structures has been undertaken. New committees were commissioned and incorporated into the clinical structure. As part of our program for continual improvement, these will be reviewed on an ongoing basis by an external consultant. A Clinical Governance Flow Chart was developed that identified the flow of the information from team meetings & the links between the various Committees, Registered Manager & Registered Person. - The identified committees are incorporated to provide best practice. These have clearly defined roles & terms of reference.

	-We have developed a Clinical Governance Quality Improvement Committee. Two lay-persons are members of this committee. The committee receives information from the team meetings, sub-group meetings, Medical Adivisory Committee and the newly developed Mortality & Morbidity Committee in the form of collated information from the Clinical Governance Officer /Infection Prevention Officer & Hospital/Registered Manager. - The Governance lead is supported in their role by the Hospital Manager, clinical Governance Links within the various Departments and the Clinical Governance Consultant. - The Hospital/Registered Manager has developed the Central Risk Register. This is shared & discussed at the clinical governance meeting and the MAC. The register identifies risks & includes all measures that are in place to mitigate the risks.
Medical Governance and Medical Advisory Committee	
Area for improvement 2 **Ref:** Regulation 17 **Stated:** First time **To be completed by:** 05 June 2019	The registered persons shall address the following matters with respect to the MAC: • ensure the committee meets on a quarterly basis (as a minimum) and arrangements are in place for extraordinary meetings, as necessary; • ensure the committee reviews information in respect of adverse clinical incidents and is advising the hospital's senior management team on corrective action when/as necessary; • ensure the committee is assisting the senior management team to assure and evidence safe practice; • ensure the committee is providing the expertise to discuss and if necessary challenge practice of individual medical practitioners; and minutes of MAC meetings must accurately reflect discussions progressed, actions agreed and persons responsible for taking forward actions within agreed timescales. Ref: 6.4.2
	Response by registered person detailing the actions taken: - The MAC has a clearly defined terms of reference. The committee currently meets every two months and will continue to meet at least quarterly from April 2020. There are arrangements in place for additional meetings to be organised in extraordinary circumstances. - The committee reviews all incidents and advises the senior management team on action that they feel is required. - The Chairman & the committee are committed to supporting the management team to ensure that safe & evidence based care is delivered within NWIH. -The committee provide expertise, and with the knowledge & support of the Responsible Officer, will if necessary, challenge practice of individual medical practitioners. -The minutes of the MAC meetings are accurately recorded to reflect the actual discussion, recommendations and any actions and the persons who have been identified to complete the actions within

	specified time-scales.
Notifiable Events/Incidents	
Area for improvement 3 **Ref:** Regulation 28 **Stated:** First time **To be completed by:** 05 June 2019	The registered persons shall address the following matters with respect to incident management: • review the current system, which is currently dependent on two members of staff, to ensure the expertise is shared more widely, to build a sustainable approach across the hospital; • review the current system of incident investigation and management to ensure it is balanced between reviewing equipment, procedures and clinical practice; and • disseminate the learning, from incidents, across all staff groups. The registered persons shall address the following matters with respect to notifications: • ensure that RQIA is informed of all incidents, in a timely manner, in keeping with RQIA's guidance document Statutory notification of incidents and deaths; • ensure that the information within the notification is sufficient in detail; and amend the current system for reporting to RQIA, via web portal, from one which is overseen by two people, to one that can be operated by more than two people. Ref: 6.4.5
	Response by registered person detailing the actions taken: - The Registered Manager has addressed the previous incident reporting system and has identified additional staff to provide a more sustainable approach across the NWIH. - The system of incident investigation and management has been reviewed to ensure it is balanced between reviewing equipment, procedures and clinical practice. - All learning is disseminated from incidents via the various team meetings, departments, & Consultants. - The registered persons can confirm that all incidents will be reported to RQIA in a timely manner as per the RQIA Statutory notification of incidents & deaths & will include sufficient detail. - The current system of reporting is now being overseen by more than two people to include Hospital/Registered Manager & Ward Manager, 2 x Deputy Ward Managers, Theatre/ Deputy Hospital Manager & Deputy Theatre Manager.
Policy/Guidance and Best Practice	
Area for improvement 4 **Ref:** Regulation 15 (1)(b)	The registered persons shall address the following matters with respect to the management of venous thromboembolism (VTE): • review the current VTE management policy and ensure that it is

Stated: First time **To be completed by:** 05 June 2019	in keeping with NICE guideline [NG89]; • ensure that the MAC contributes to and approves the updated VTE policy; • ensure that VTE risk assessments are undertaken and documented in respect of all patients admitted for surgical procedures; and develop a rolling audit programme to provide assurance that the VTE policy is being adhered to. Ref: 6.5.8
	Response by registered person detailing the actions taken: -The VTE management policy has been reviewed to reflect the NICE guideline (NG89.) -This has been shared at the MAC and their recommendations included. -As part of our system of continual improvement and following receipt of further input from the MAC the policy is being developed further. This will reviewed at the MAC for approval prior to circulation. -All patients that are admitted for a surgical procedure are to undergo a VTE assessment. - There is an ongoing monthly audit that the CGO/IPC Officer completes after it has been collated by a staff member. This is shared at the MAC to monitor & identify any shortfalls and initiate actions to ensure that the policy is adhered to.
Laser Safety	
Area for improvement 5 **Ref:** Regulation 18 (2) (a) **Stated:** First time **To be completed by:** 05 June 2019	The registered persons shall ensure that records are retained to evidence that all clinical authorised operators using the laser have completed training in keeping with RQIA training guidance for cosmetic laser services. Ref: 6.5.9
	Response by registered person detailing the actions taken: The clinical authorised operators who use the laser have records retained as evidence that they have completed training in line with the RQIA training guidance for cosmetic laser services. - there are suitably qualified staff, competent & experienced persons working in the service as appropriate for the health & welfare of the service user. -there are management & governance systems in place that drive quality improvement, including review of policies, liaison with Laser Protection Officer.
Regulation 26 Unannounced Quality Monitoring Visits	
Area for improvement 6 **Ref:** Regulation 26 (4)	The registered persons shall ensure that unannounced quality monitoring visits are undertaken in keeping with Regulation 26. The report generated as a result of these visits should clearly reflect the outcome of discussions with patients and staff. It should also

Stated: First time **To be completed by:** 05 June 2019	comment on the governance and oversight arrangements reviewed in order to provide assurance on the quality and standard of services being provided. Ref: 6.4.3
	Response by registered person detailing the actions taken: In addition to their regular announced visits, the registered person, who is not in day-to-day charge of the establishment, has visited the NWIH & will visit the NWIH unannounced, every 6 months. The report generated as a result of the visit included: - Discussion with patients to ensure that the care & standard of treatment allowed the Registered Person to form an opinion. - Discussion with employees to allow staff to highlight any concerns and the RP to record any outcomes of the discussion - Complaints records were inspected and a review of the audits compiled by the CGO/IPC Officer was completed. - The RP reviewed & will review information in relation to the Medical Advisory Committee, Clinical Incidents, Accident Register, Central Risk Register, Clinical Governance Departmental Meetings Schedule and any other available information required to establish a general overview of the governance arrangements to assure him of the quality of the service delivered at NWIH.
Staffing Levels	
Area for improvement 7 **Ref:** Regulation 26 (4) **Stated:** First time **To be completed by:** 05 June 2019	The registered persons shall undertake a review of current staffing levels to ensure that sufficient staff are available to enable: • staff who have specialist/leadership roles have protected time in order to fulfil the roles and responsibilities assigned to them; • staff to undertake designated training, attend departmental meetings and complete an annual appraisal; and • staff the opportunity to attend safety briefings. Ref: 6.5.1
	Response by registered person detailing the actions taken: -The registered persons have undertaken a review of staffing levels and employed additional staff to ensure that the staff who have specialist roles are identified on the off-duty and are able to fulfil their roles & responsibilities in protected time. - staff are allocated time to undertake designated training, attend Departmental Meetings & have their Appraisal completed. - staff have the opportunity to attend safety briefings.The ward staff receive the report & the safety briefing is signed & dated. Theatre staff have established a theatre briefing system that is completed at the beginning of the list identifying any concerns & is completed at the end of the list to identify any opprtunities for learning.

Medical Cover	
Area for improvement 8 **Ref:** Regulation 18 (1) **Stated:** First time **To be completed by:** 05 June 2019	The registered persons shall review the arrangements in respect of medical cover to ensure that: • there is a member of staff onsite providing medical cover at all times; • the medical cover rota is displayed in all clinical areas; • the roles and responsibilities of staff providing medical cover are clearly defined; • that staff providing medical cover undertake a handover at shift change; and • that staff providing medical cover have access to advice and support from consultants; and that the medical cover rota takes into account the needs of the patient group accommodated within the hospital, with particular attention being paid to children and young people. Ref: 6.5.2
	Response by registered person detailing the actions taken: - The registered persons have recruited Resident Medical Officers that provide cover from 7am - 7pm, 7 days a week. There is a pool of on-call doctors that continue to cover the overnight (7pm - 7am) Medical cover. This ensures that there is a medical practitioner providing medical cover at all times. -The medical cover rota is displayed in all clinical areas. - There is a fully comprehensive & clearly defined role & responsibilities & induction for the staff providing medical cover. -There is always access to the the relevant Consultant for advice & support. -The Medical cover provided has & will take into account the needs of the patient group that are being treated within the NWIH in particular Paediatric & Young People.
Audit	
Area for improvement 9 **Ref**: Standard 17.1 **Stated:** First time **To be completed by:** 05 June 2019	The registered persons shall address the following matters with respect to audits: • ensure that robust arrangements are established to escalate issues identified during the audit process through the hospitals governance structures; and • ensure that the audit of core key quality indicators is submitted and reviewed by the MAC and other key governance committees and evidence of actions taken to address shortfalls recorded. Ref:6.4.8
	Response by registered person detailing the actions taken: -The Registered persons have reviewed the process to escalate

	issues that are raised during the audit process via the CGO/IPC Officer so that matters are shared & actions are identified & the staff member allocated the task completes it in the recommended timeframe. - There is a rolling continuing audit of the key quality indicators completed by the Hospital/Registered Manager and submitted to MAC & Mortality & Morbidity Committee & Clinical Governance & Quality Improvement Committee & RP. There is evidence of actions advised to address any shortfalls & recommendations to enhance practice.
Medicines Management	
Area for improvement 10 **Ref**: Standard 20.2 **Stated:** First time **To be completed by:** 05 June 2019	The registered persons shall strengthen infection prevention and control (IPC) procedures as follows: • ensure that the NWIH develops an anti-microbial/antibiotic stewardship policy in keeping with NICE guideline [NG15]; • ensure the MAC liaises with consultant surgeons and contributes to the development of the policy; • ensure the policy clearly specifies the prophylaxis medications that can be prescribed by surgeons; and • ensure that a rolling audit programme is developed to provide assurance that the policy is being adhered to. Ref: 6.5.13
	Response by registered person detailing the actions taken: -The CGO/IPC Officer has strengthened the infection prevention and control procedures to ensure that the anti-microbial/antibiotic stewardship policy is as per NICE guideline (NG15). -Th Anti-microbial/antibiotic stewardship policy has been shared at the MAC & has included any recommendations & contributions from the consultants after being discussed- it is to be signed off 11/12/2019 by the MAC. -There is specific guidance on the prophylaxis medications that can be prescribed by the surgeons. - A rolling audit programme has been developed and will identify any shortfalls, this will initiate action and assure the Registered Persons that the policy is adhered to.
Area for improvement 11 **Ref**: Standard 27.4 **Stated:** First time **To be completed by:** 12 April 2019	The registered persons should ensure that controlled drug registers are fully and accurately completed and a regular auditing process is in place. Actions taken to address issues identified as a result of audits should be recorded and learning disseminated to appropriate staff. Ref: 6.5.11
	Response by registered person detailing the actions taken: -The registered persons have identified the Theatre Manager to monitor the completion of the controlled registers to reflect an accurate recording of administration. There is a rolling audit programme in place which is then audited by CGO/IPC Officer.

	-If actions are identified to address deficits these are recorded & it is the CGO/IPC Officer responsibility to share at meetings i.e. MAC, Team meetings and sub-group meetings & Clinical Governance Quality Improvement Meetings.
Infection Prevention and Control	
Area for improvement 12 **Ref**: Standard 13.3, 20.3 **Stated:** First time **To be completed by:** 05 June 2019	The registered persons shall address the following matters with respect to Aseptic Non Touch Techniques (ANTT) used during clinical practices: • further develop the training programme and ensure it is delivered to appropriate staff; • ensure staff who have completed ANTT training are competency assessed; and • develop a rolling audit programme to provide assurance that staff are adhering to best practice following training. Ref: 6.5.13
	Response by registered person detailing the actions taken: The training programme delivered by the CGO/IPC Officer has been reviewed to ensure staff are competency assessed & a practical element is included. The CGO/IPC will audit performance on an ongoing basis to ensure that staff are adhering to best practice, following training.
Area for improvement 13 **Ref**: Standard 22.1 **Stated:** First time **To be completed by:** 05 June 2019	The registered persons shall ensure that cleaning schedules are completed and audited. Arrangements should be established to address any shortfalls identified through the audit process. Ref: 6.5.13
	Response by registered person detailing the actions taken: The registered persons have evidence that cleaning schedules are being completed & there is a rolling audit to establish shortfalls, and an action plan to address any concerns.
Management of Complaints	
Area for improvement 14 **Ref**: Standard 7.1 **Stated:** First time **To be completed by:** 05 June 2019	The registered persons shall ensure that the themes emerging from complaints analysis are shared with the MAC and other relevant governance committees. Actions taken to address themes should be recorded; learning from complaints should be disseminated across all staff groups. Ref: 6.4.4
	Response by registered person detailing the actions taken: The registered persons & Responsible Officer receive an update

	regarding complaints & analysis from the CGO/IPC Officer. This is shared at the MAC and the Clinical Governance & Quality Improvement Meeting. Any trends are identified & if further action is required & lessons learnt are shared at the various Team Meetings.
Endoscopy/Estates	
Area for improvement 15 **Ref: Standard 21.2** **Stated: First time** **To be completed by:** 05 June 2019	The registered persons shall fully implement the key audit findings issued by DoH Health Estates in relation to the premise's endoscopy decontamination equipment, facilities and processes. Ref: 6.5.6
	Response by registered person detailing the actions taken: The registered persons have ensured that the SSD Manager has completed the key audit findings issued by the DoH Health Estates -Job roles:It was identified that the role of AP(D) incorporated into the role of SSD manager caused a conflict of interest. A second staff member is scheduled to be trained in this role- the next available training is 16th-19th December 2019, this has been booked.The Quality Managememt Systems & Procedures have been updated to reflect the new role. Permit to work system- this does not appear to be a requirement in HTM01-01/06. However,the permit to work system has been incorporated into the daily running of the department to cover all breakdowns,services & validations. Wasserburg AER HTM 01-06 conformity-Currently Wasserburg is serviced and validated by Wasserburg Ireland- thay have been advised to ensure that the test report reflects HTM01-06 guidelines. Further test was completed on the 14th & 15th May 2019. Surestore System of validation reports has been reviewed and will conform to the criteria set by DoH. The Technical file has been updated to reflect the enhanced system of more frequent visits, independent monitoring system,reduction of colonoscopies shelf-life to 35 days,and the inclusion of of Surestore to our network.

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

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