COVID-19 Independent Hospital Unannounced Inspection Report 25 March 2021

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

Jo Browne	Senior Inspector, Independent Health Care Team, Regulation and Quality Improvement Authority
Stephen O'Connor	Inspector, Independent Health Care Team, Regulation and Quality Improvement Authority
Emer McCurry	Inspector, Independent Health Care Team, Regulation and Quality Improvement Authority
Carmel McKeegan	Inspector, Independent Health Care Team, Regulation and Quality Improvement Authority
Dr Ian Gillan	Laser Protection Advisor, Regulation and Quality Improvement Authority
Rachel Lloyd	Inspector, Pharmacy Team, Regulation and Quality Improvement Authority
Phil Cunningham	Senior Inspector, Estates Team Regulation and Quality Improvement Authority

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

1.0 What we look for

2.0 Profile of service

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 surgery 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) Acute Hospital Day Surgery AH(DS) Prescribed Technologies, Endoscopy PT(E) Prescribed Technologies, Laser PT(L) Private Doctor (PD)	**Number of registered places:** 35 in patient 13 day surgery places

Laser equipment

Manufacturer:	Ceramoptec Biolitec
Model:	Ceralas E
Serial Number:	4291G
Laser Class:	4
Wavelength:	1470nm
Laser protection advisor (LPA):	Mr Philip Loan, Onephoton
Laser protection supervisor (LPS):	Mr Zola Mzimba
Medical support services:	Mr Zola Mzimba
Clinical authorised operators:	Two named Consultant surgeons
Non–clinical authorised operators:	Ms Laura Cave
Types of treatment provided:	Endovenous closure using laser therapy

4.0 Inspection summary

In response to the COVID-19 pandemic we introduced a series of Infection Prevention and Control (IPC) inspections of Health and Social Care (HSC) acute and independent hospitals across Northern Ireland. This programme of inspections was undertaken following receipt of information by members of the public who were concerned with IPC practices when they visited our hospitals.

We undertook an unannounced inspection to North West Independent Hospital on 25 March 2021.

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). The inspection framework also draws on best practice guidance from a range of sources including Public Health Agency Northern Ireland (PHA), Department of Health (DoH) Northern Ireland and Public Health England (PHE).

We sought assurances across the following key criteria to determine if each hospital inspected had an effective approach to infection control:

- governance and collaborative working across the hospital;
- risk assessment;
- audits of staff practices;
- staff work patterns;
- staff training;
- environment and cleaning practices;
- observations of staff practice;
- information sharing;
- innovative practice;
- supporting patients and visitors; and
- support for staff.

The Laser Protection Advisor for RQIA reviewed the safety measures in place to manage and maintain the current laser. The findings and laser safety report is appended to this report.

The focus of this inspection was to assess the hospital's arrangements regarding a COVID-19 safe environment. We additionally reviewed areas for improvement stated within the quality improvement plan (QIP) from the previous unannounced inspection from 20 to 22 January 2020.

We spoke with a range of staff, including managers, nursing, medical staff and domestic services staff. We observed IPC practices and spoke with staff to determine their knowledge and understanding of the current best practice guidance in relation to IPC.

The inspection to North West Independent Hospital has highlighted numerous strengths in achieving and maintaining a COVID-19 safe environment. We were assured of robust governance and oversight of measures to prevent the spread of the virus. We found evidence of collaborative and multi professional working and good communication systems for the sharing of information and learning. We found that overall COVID-19 risk assessments were comprehensively completed for clinical and non-clinical areas and many environmental control measures were implemented to reduce the risk of transmission of the virus. We were assured that staff have received enhanced IPC training and systems were in place for the monitoring of staff practices.

We found that staff had a good understanding of the measures to prevent transmission of the virus and this was further supported in our observations of their practices. We observed effective hand hygiene practices and a good use of personal protective equipment (PPE). In addition we observed staff supporting patients to comply with IPC measures. We observed an excellent standard of environmental and equipment cleaning and good signage to direct visitors and staff.

One area for improvement made against the standards during the previous inspection in relation to updating the IPC policy has been stated for the second time. Three new areas for improvement have been made against the regulations and standards. These relate to medical governance, updating the laser safety policy and formalising the arrangements for the safe custody of the laser keys.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	3

This inspection resulted in one area for improvement being identified against the regulations and three against the minimum standards. This includes one area for improvement against the standards which was stated for the second time.

On the day of inspection we provided feedback to Ms Carmichael, Registered Manager, regarding the inspection findings. During this meeting, we discussed the hospital's strengths and also recommended some practical measures to enhance documentation.

This inspection did not result in enforcement action.

5.0 How we inspect

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

- the registration status of the establishment;
- written and verbal communication received since the previous inspection;
- the previous inspection reports;
- the returned QIP from the previous care inspection;
- Serious Adverse Incident (SAIs) notifications;
- information on Concerns;
- information on Complaints; and
- other relevant intelligence received by RQIA.

During our inspection, we assessed both a number of clinical and non-clinical areas using an inspection framework that draws from a range of best practice sources in the management of COVID-19.

We inspected a number of clinical areas which included the Outpatient Department (OPD) and associated waiting areas; Ward1, Ward 2, and the theatre department including the laser equipment. We also inspected a number of non-clinical areas in the hospital including the main entrance/reception to the hospital; access corridors and the canteen.

We examined records in relation to each of the areas inspected, and we spoke with staff and observed their IPC practices. We carried out assessments of the physical environment and reviewed the infection control measures implemented to reduce risk of transmission of the virus.

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

We invited staff and patients to complete an electronic questionnaire during the inspection. No patient questionnaires were received by RQIA. Returned staff questionnaires are discussed in section 6.3.11 of this report.

It was agreed with the DoH that where an independent hospital provides treatments using endoscopes that the arrangements for the decontamination of endoscopes would be reviewed. On the day of inspection NWIH was provided with a hard copy and electronic copy of the Institute Of Healthcare Engineering & Estate Management Joint Advisory Group (on GI Endoscopy) audit tool. The audit is to be completed and returned to Phil Cunningham, Senior Estates Inspector, RQIA within one month of the inspection, following which the completed audit will be reviewed and report issued under separate cover. Additional information in this regard can be found in section 6.4.2 of this report.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspections from 20 to 22 January 2020

We previously carried out an unannounced inspection to North West Independent Hospital from 20 to 22 January 2020.

6.2 Review of areas for improvement from the previous inspection from 20 to 22 January 2020

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Minimum Care Standards for Independent Healthcare Establishments (2014)</th><th>Validation of compliance</th></tr>
<tr><td colspan="3">Venous Thromboembolism (VTE) risk assessment</td></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Regulation 15 (1) (b)

Stated: Second time</td><td>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 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.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This area for improvement has been assessed as met. Further detail is provided in section 6.5.1.</td></tr>
<tr><td colspan="3">Laser safety</td></tr>
<tr><td rowspan="2">Area for Improvement 2

Ref: Regulation 18 (2) (a)

Stated: Second time</td><td>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.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This area for improvement has been assessed as met. Further detail is provided in section 6.4.1.</td></tr>
</table>

Medical governance		
Area for improvement 3 **Ref: Standard 29.2** **Stated: First**	The Registered Persons in conjunction with the MAC and Responsible Officer (RO) should further develop the role of the Resident Medical Officers (RMOs). Following which each RMO should be provided with an updated copy of their job description.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.5.2.	
Practising privileges		
Area for Improvement 4 **Ref: Standard 11.1** **Stated: First time**	The Registered Persons shall ensure practising privileges agreements are renewed when due and that the MAC are informed if medical practitioners do not submit requested information within specified timeframes.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.5.3.	
User rights agreements		
Area for Improvement 5 **Ref: Standard 11.1** **Stated: First time**	The Registered Persons shall confirm in writing that the practice of granting user rights to Allied Health Professionals (AHPs) providing services within the hospital has ceased as described to us during the feedback meeting on 22 January 2020. Services can only be provided by AHPs who are directly employed by the hospital or who have practising privileges agreements in place.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.5.4.	

Patient records		
Area for Improvement 6 **Ref: Standard 10.4** **Stated: First time**	The Registered Persons shall ensure that an audit of medical records is undertaken to ascertain if records are in accordance with General Medical Council (GMC) Good medical practice guidance. An action plan should be generated to address any deficits identified. Findings of the audit should be shared with the MAC.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.5.5.	
Quality assurance		
Area for Improvement 7 **Ref: Standard 9.3** **Stated: First time**	The Registered Persons shall develop an audit programme ratified by the Medical Advisory Committee (MAC). Consideration must be given to how audit findings are analysed for trends/comparative data, and how audit findings are shared with relevant governance committees and staff.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.5.6.	
Staffing		
Area for Improvement 8 **Ref: Standard 10.6** **Stated: First time**	The Registered Persons shall ensure that all staff have an annual appraisal by an appropriately trained and qualified appraiser.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.5.7.	
Central Sterile Servicing Department (CSSD)/endoscopy arrangements		
Area for Improvement 9 **Ref: Standard 20.3** **Stated: First time**	The Registered Persons shall ensure that the identified staff member has completed the Authorised Person (Decontamination) AP (D) course. A copy of the training certificate should be submitted to RQIA.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.5.8.	

Laser safety		
Area for Improvement 10 **Ref: Standard 48.20** **Stated: First time**	The Registered Persons shall ensure that the laser is serviced and a copy of the service report submitted to RQIA upon return of this quality Improvement plan (QIP).	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.4.1.	
Medicines management		
Area for Improvement 11 **Ref: Standard 25.12** **Stated: First time**	The Registered Persons shall ensure arrangements are established and embedded into practice to audit medicine Kardexes. An action plan should be generated to address any deficits identified as a result of audits. Findings of audits should be shared with the pharmacist and governance committees.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.5.9.	
Resuscitation and management of medical emergencies		
Area for Improvement 12 **Ref: Standard 18.3** **Stated: First time**	The Registered Persons shall ensure that appropriate medical emergency medicines and equipment are available in the outpatient department. A risk assessment must be completed to determine the arrangements to be put in place, consideration should be given to best practice guidance. The outcome of the risk assessment must be ratified by the Medical Advisory Committee (MAC).	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.5.10.	

Environment		
Area for Improvement 13 **Ref: Standard 20.2** **Stated: First time**	The Registered Persons shall ensure that the arrangements specified in the hospital's IPC policy in relation to flagging a patient's infection risk is embedded into practice, including how this is recorded and communicated through the various departments. When the IPC policy is amended or further developed in this regard the refreshed policy must be in accordance with The Northern Ireland Regional Infection Prevention and Control Manual.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as not met and has been stated for a second time. Further detail is provided in section 6.5.11.	
Care pathway		
Area for Improvement 14 **Ref: Standard 9.1** **Stated: First time**	The Registered Persons shall undertake a review of nursing tools currently being used across all departments to ensure that they are up to date and in keeping with the current evidence base and best practice guidelines. Should new nursing tools be introduced, staff should be trained in their use and an auditing process implemented to provide the necessary assurances.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.5.12.	
Staffing		
Area for Improvement 15 **Ref: Standard 16.2** **Stated: First time**	The Registered Persons shall appoint an external independent organisation or human resource advisor to undertake a cultural assessment of the hospital. An action plan should be generated to address any recommendations contained within the report detailing the main findings of the cultural assessment.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.5.13.	

6.3 Inspection findings

6.3.1 Governance and collaborative working

The COVID-19 pandemic has presented significant challenges in respect of how hospital care is planned and delivered. Changes that would typically take months or years to come into effect have been agreed and implemented at speed and under huge pressures while ensuring the hospital remains a safe environment for patients and staff. Incorporating these changes requires effective governance arrangements, which are underpinned by good business management and the application of clear strategic and organisational objectives.

We sought assurance of effective governance arrangements in the planning and delivery of IPC measures by reviewing key areas of collaborative working, communication systems, COVID-19 risk assessments, the monitoring of staff practices, work patterns and staff training. Senior staff told us that the hospital had reviewed and implemented measures to promote a COVID-19 safe environment in all areas of the hospital.

We reviewed a selection of documentation including minutes of meetings; risk assessments; audits of the environment and staff practices; and staff training records. We confirmed good governance measures in place for the preparation of the hospital in the implementation of a COVID-19 safe environment. We also reviewed notifications and concerns reported to RQIA and the management of incidents. We were assured of good governance systems in place and regular meetings held, represented by key individuals in the organisation to discuss and share information.

We met with the Registered Manager and we were informed their aim was to provide assurance to the senior management team (SMT) in relation to the hospital's accountability for the safety, health and wellbeing of staff, patients and service users during the COVID-19 pandemic. We were told that a collaborative approach ensured efficiency and consistency in the implementation of IPC measures throughout the hospital to promote a safer workplace.

We found evidence of information sharing between departments and minutes of meetings confirming collaborative working between all disciplines and clear pathways of information flow through different levels of management.

Staff spoke of their input at a variety of meetings that were established to agree processes to ensure a safer workplace. Staff told us how they worked collaboratively, to identify risks and implement risk reducing measures in all clinical and non-clinical areas. Staff were complimentary of the support provided by the Registered Manager and SMT.

We found effective governance arrangements underpinned by clear strategic and organisational objectives aimed at preventing the spread of the virus. We found evidence of collaborative and multi professional working and good communication systems for the sharing of information and learning.

6.3.2 COVID-19 risk assessments

There was evidence of collaborative work between the hospital's management team, heads of department and clinical staff in the development of the COVID-19 environmental risk assessments. This tool was used to support staff to recognise and manage the COVID-19 infection risk. We met with senior staff who told us that a risk assessment was undertaken in all communal areas inclusive of the restaurant and receptions. We heard how control measures were continuously being reviewed and updated to optimise solutions.

We reviewed the COVID-19 general risk assessment for the entire NWIH which included clinical and non-clinical areas, highlighting location specific parameters such as wards/day procedure unit/reception and the canteen. The general risk assessment also highlighted that staff should carry out COVID-19 screening for all attendees to the hospital. We observed this in place at the entrance to the hospital.

We observed that staff adhered to social distancing measures and we were pleased to note that actions were taken to address the practical amendments during our inspection to the hospital.

COVID-19 risk assessments with agreed action plans were also completed by line managers for shielding staff returning to work, to protect them against exposure to the virus in the workplace.

The risk assessments included discussions with the staff member in respect of IPC precautions to be taken and considered options for staff including review of work conditions and working from home where possible.

We were assured that the hospital had robust measures in place to protect patients and staff.

6.3.3 Sharing of information

Staff in all areas informed us that they have access to up to date policies and procedures, and were provided with updates in a number of different ways including by email, staff handovers and staff meetings.

Senior staff explained how they were represented at multidisciplinary meetings with the use of virtual platforms such as 'Zoom' to communicate. Management noted that virtual meetings afforded a higher attendance by staff as opposed to face to face meetings due to the social distancing measures.

Information and posters were also displayed for staff. Importantly all staff were aware of the procedures to be followed if they became unwell.

In the hospital, we found clear lines of communication to connect efficiently with key stakeholders both internally and externally. A range off multimedia platforms such as emails, intranet postings and posters were available to provide staff with the latest updates on COVID-19.

6.3.4 Auditing of staff practices

We reviewed a range of audits undertaken in clinical areas including, environmental and hand hygiene audits which confirmed good compliance. We also reviewed evidence of the actions which had been taken to address areas requiring improvement, where necessary.

We were satisfied that the hospital had robust measures in place to monitor staff practices.

6.3.5 Staff work patterns

As part of a regional response to COVID-19 the Department of Health (DoH) has commissioned services from the independent sector and this involved staff in the hospital providing services such as additional elective surgery. Staff demonstrated considerable resilience, willingness to adapt and learn new skills in preparation for taking on these new services.

We were informed that all staff have been very flexible in their availability to ensure patient appointments and surgical procedures are provided and that there are appropriately skilled and experienced staff in place at any given time to meet the needs of the patients.

6.3.6 Staff training

We reviewed training records for staff in relation to IPC and found that mandatory IPC training was up to date. Additional training for staff in donning and doffing of PPE and training on the completion of risk assessments in the workplace has been facilitated by the Clinical Governance Officer and Infection Control Advisor (CGO) for the hospital. Online educational resources were also available for staff to access.

When we spoke with staff they confirmed that they had received training on donning and doffing of PPE and that they have access to online training material.

6.3.7 Environment and cleaning practices

The standard of environmental cleaning throughout the hospital was excellent. Non-clinical areas such as entrances, reception areas, public toilets and clinical areas, side rooms and sanitary areas throughout the wards and departments were clean, tidy and uncluttered. The hospital had implemented successful intensive cleaning programmes targeted at surface decontamination.

Communal areas inclusive of the canteen, staff break out areas, corridors, and reception areas were all clearly identified with posters and floor markings highlighting social distancing measures and IPC guidance. One way entry/exit systems were evident at the entrance to the hospital and to the canteen. We noted that additional staff dining rooms had been identified to ensure that staff could adhere to social distancing measures.

We observed the use of chair blocking in waiting areas to facilitate social distancing and posters displayed to direct staff and patients in the correct IPC precautions to be taken in a particular area. We observed a number of chairs in the outpatient waiting area had torn coverings exposing the underlying foam/cushion. This was brought to the attention of Ms Carmichael and the identified chairs were removed before the conclusion of the inspection.

Environmental cleanliness in all areas, clinical and communal, was of a high standard and the environment was well maintained and clutter free. Cleaning rotas have been enhanced to increase the frequency of cleaning of high touch points such as door frames and switches for example. Key performance indicators were displayed to provide assurance of audit and monitoring of staff practices and environmental cleanliness. Environmental cleanliness scores were available providing assurance of a good standard of environmental cleaning. We were provided with evidence of actions taken when environmental standards were below the expected standard of cleaning.

We were assured that the hospital was taking all necessary environmental steps to reduce the risk of infection throughout the hospital.

6.3.8 Observations of staff IPC practices

We spoke to a range of staff in all clinical areas, and found them to be knowledgeable on IPC practices. Observations of staff IPC practices in both clinical and non-clinical areas when undertaking hand hygiene practices, using PPE and environmental and equipment cleaning supported this finding. Staff were observed to undertake opportunities for hand hygiene at appropriate times in line with hospital policy and best practice guidance. We observed staff were compliant with the dress code policy. Overall, PPE was accessible and worn appropriately in line with current guidance. Additionally, in line with COVID-19 guidance, we observed staff adhering to social distancing and wearing of face masks in non-clinical areas such as corridors and offices.

We reviewed cleaning schedules and checked items of patient equipment in wards and the theatre department and found them to be clean and fit for purpose. The management of sharps and segregation of waste was in line with hospital policy.

One way systems and social distancing by staff and patients were generally well adhered to in both clinical and non-clinical areas. We observed mechanisms in place at the OPD to challenge non-adherence when social distancing measures were breached. All staff questioned stated they would be happy to challenge anyone not compliant with any aspect of COVID-19 precautions. All staff confirmed that they would be happy to escalate concerns through line management structures.

6.3.9 Innovative practices

In response to the COVID-19 pandemic, the North West Independent Hospital extended the main entrance of the hospital by building a temporary annex. This new annex provided additional space to facilitate social distancing. Staff were present in this area and were responsible for ensuring only people who had an appointment entered the building. We observed staff undertaking COVID-19 screening questions and directing patients/visitors to the appropriate area of the hospital. The new entrance area also facilitated a one way system and provided a separate exit.

We observed that the hospital had risk assessed and subsequently reviewed the provision of staff rest areas and office areas. Additional staff rest areas were provided by repurposing rooms and spaces where possible within different departments. We also found that rooms had been temporarily repurposed to ensure administration staff were facilitated to continue to work safely.

6.3.10 Patient and visitor support

We invited patients to complete an electronic questionnaire during the inspection. No patient questionnaires were received by RQIA during or following the inspection.

We did not have an opportunity to speak to patients or visitors during the inspection; we were informed visitors were not permitted unless accompanying a child attending an outpatient appointment.

6.3.11 Support for staff

We spoke to staff face to face, those engaged with included the following:-

- Responsible Individual;
- Registered Manager;
- Clinical Governance Officer and Infection Control Advisor (CGO)
- Resident Medical Officer;
- Human Resources Manager;
- Quality Management Consultant
- Medical secretary and secretary to the MAC;
- Lead receptionist;
- Heads of department (theatre, CSSD, Estates team)
- Nurse in charge of inpatient unit;
- Nursing staff;
- Domestic staff.

We found staff at all levels to be helpful and supportive throughout the inspection.

In the clinical areas we observed that the nurse in charge was visible and provided good leadership. Staff told us of the fear they experienced at the start of the pandemic. They have received good support from each other, their line managers, and senior management. Staff reported being proud of the good team work on the wards and appreciated the peer support during the pandemic.

We invited staff to complete an electronic questionnaire during the inspection. Seventeen 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	Dissatisfied	Very Dissatisfied
Safe	6	5		3	1
Effective	6	7		2	
Compassionate	7	8			
Well led	4	6	1	2	2

Six staff responses included comments. Four of these comments were positive in nature with staff telling us about the high quality of care delivered; that the hospital is modernising and investing in staff training; that a greater focus is being placed on structures to empower staff to drive improvements. However, two of the comments included concerns in relation to low staff morale; resilience on agency staff and a continued culture of bullying and harassment.

Following the inspection these findings of the staff survey were shared with Ms Carmichael who agreed to share the findings with heads of department so that they can discuss during planned staff meetings.

6.4 Additional areas examined

6.4.1 Laser safety

We reviewed the arrangements in respect of the safe use of the laser equipment in the hospital. A senior staff member informed us that, due to the impact of the COVID-19 pandemic, laser treatments have been temporarily suspended.

We found a laser safety file was in place that in general contained all of the relevant information.

There was written confirmation of the appointment and duties of a certified Laser Protection Advisor (LPA). We reviewed the service level agreement between the hospital and their LPA and found this to be a satisfactory arrangement.

We reviewed the hospital's 'General Policy 23 – Use of Lasers within North West Independent Hospital' and found that large sections of this document are a duplicate of the Local Rules. The hospital should seek advice from their LPA to amend this document to provide an overarching statement on the approach to laser safety making reference to the existence of Local Rules and the medical treatment protocols. An area for improvement has been identified against the standards in this regard.

We established that two named Consultants, in accordance with the medical treatment protocols, undertake procedures using the laser equipment.

We reviewed the medical treatment protocols review timetable which stated that the treatment protocol dated 10 December 2019 should have been reviewed in December 2020. We advised that this review should be completed before the next session of laser treatments are booked.

We found the Local Rules, developed by the LPA, contained relevant information pertaining to the laser equipment being used and these had been signed by the both Consultants. We reviewed the Local Rules and noted that Section 7 of the Local Rules refer to protective eyewear with a minimum rating of 1400LB2. We felt this was probably a typographical error as the laser output occurs at 1470nm and advised that hospital brings this to the attention of their LPA to address. We noted a list of staff identified as 'non-clinical users' had signed a declaration stating that they have read and understood the Local Rules. As this group of staff do not 'use or operate' the laser we advised that this group should be renamed as 'assisting staff'.

The Local Rules refers to a safe system for storage of the key to switch on the laser. We were informed of the arrangements for safe storage of the laser key however these arrangements were not documented. We advised that a policy for the safe storage of the laser key is developed, shared with all relevant staff and retained in the laser safety file. An area for improvement has been identified against the standards in this regard.

A list of clinical authorised operators was maintained. The laser was used by authorised operators who have received the appropriate training and experience in accordance with the relevant discipline within which the treatment was provided. Training records were available for each authorised operator in relation to laser safety; core of knowledge and application training for the specific laser system; fire safety; and basic life support. We noted that IPC and safeguarding training records were not available. We were informed that this training had been undertaken and that verification of this would be provided. On 1 April 2021 we received documents which evidenced that both authorised operators had completed training in these areas which was current and up to date. We observed a process was in place to monitor training and ensure compliance in this area.

We found clear identification of the authorised Laser Protection Supervisor (LPS) and arrangements for deputisation. When the laser is in use, the safety of all persons in the controlled area is the responsibility of the LPS. The environment in which the laser equipment is used was found to be safe and controlled to protect other individuals while treatment is in progress. The controlled area was clearly defined and not used for other purposes or as access to other areas during surgery.

There are two doors to the laser suite and we were informed that both are locked when the laser is in use but can be opened from the outside in the event of an emergency. Staff told us that laser safety warning signage is displayed/illuminated when the laser equipment is in use and turned off when not in use.

We reviewed the service arrangements and found the laser service report of March 2020 stated that the next service was due in March 2021. We established that due to current travel restrictions affecting service engineers this service had not yet been carried out. As previously discussed the hospital is not currently using the laser, we therefore advised that a service should be arranged before further laser sessions are scheduled.

We reviewed the laser surgical register which is completed every time the equipment is operated and evidenced that it included the following information:

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

At the end of each treatment, a record was made in the laser register of the frequency and single pulse energy settings displayed on the laser control panel. We were satisfied the total energy delivered during each treatment session had been consistently recorded.

6.4.2 Decontamination of endoscopes

We found arrangements were in place to ensure the decontamination of equipment and reusable medical devices in line with manufacturer's instructions and current best practice. NWIH has its own accredited central sterile services department (CSSD) for the decontamination of flexible endoscopes and reusable medical instruments.

As discussed in section 4.0 of this report in response to the COVID-19 pandemic we introduced a series of series of IPC inspections of Health and Social Care (HSC) acute and independent hospitals across Northern Ireland. It was agreed with representatives at the DoH that these IPC inspections would include a review of the decontamination of endoscopes where applicable.

On the day of inspection NWIH was provided with a hard copy and electronic copy of the Institute Of Healthcare Engineering & Estate Management Joint Advisory Group (on GI Endoscopy) audit tool. The audit is to be completed and returned to Phil Cunningham, Senior Estates Inspector, RQIA within one month of the inspection, following which the completed audit will be reviewed and a report issued under separate cover.

6.5 Additional areas inspected to review previously identified areas for improvement

6.5.1 Venous Thromboembolism (VTE) risk assessment

We assessed the management of VTE risk assessments and thrombo-prophylaxis prescribing within the hospital. We reviewed the VTE management policy and found that it had been updated in March 2020 in keeping with NICE guideline [NG89]. The policy had been shared with and ratified by the Medical Advisory Committee (MAC).

We established that VTE risk assessments are completed by the Resident Medical Officer (RMO), for every adult undergoing surgery, on admission and VTE thrombo-prophylaxis medication was prescribed as directed by the hospital's policy. The VTE risk assessment and prescribing must be completed within 14 hours of admission or prior to surgery. Where VTE thrombo-prophylaxis prescribing differs from the agreed hospital's policy the rationale for this must be recorded in the patient's medical and nursing care records and supported by evidenced based practice. We reviewed three patient VTE risk assessments and found that these had been managed appropriately in line with the VTE policy.

We met with the CGO and found that VTE audits are completed as part of the hospital's rolling audit programme which has been ratified by the MAC. We reviewed the most VTE audit undertaken in February 2021 which reflected high compliance with the VTE policy and prescribing of thrombo-prophylaxis. Actions plans are developed to address any improvements required. Results of the audit are shared with MAC and the Responsible Individual (RI) and referenced in the MAC Minutes and RI report. We determined that this addressed the previously identified area for improvement 1 as outlined in section 6.2.

6.5.2 Medical Governance

We confirmed that the RMO's role and job description had been further developed and ratified by the MAC. We determined that this addressed the previously identified area for improvement 3 as outlined in section 6.2.

We reviewed the RMO induction template and noted that it made no reference to the hospital's medical governance structures or outlined the person responsible for the day to day management and supervision of the RMOs' clinical practice. We were advised that this was previously overseen by the hospital's Responsible Officer (RO), however, due to the pandemic the RO had not been present, as often, on site. This area of medical governance requires to be strengthened and an area for improvement had been made to update the RMO induction template to include the medical governance structures of the hospital and include the arrangements for the day to day management and supervision of the RMOs' clinical practice. The management and supervision arrangements for RMO's should be clearly visible within the hospital's governance structures.

6.5.3 Practising privileges

We confirmed that a named individual (a medical secretary and secretary to the MAC) is responsible for collating the required information with regards to practising privileges and sharing this information with the MAC. We reviewed minutes of five MAC meetings between June 2020 and March 2021 and evidenced that practising privileges was routinely discussed. We were satisfied that robust arrangements were in place with regard to the management of practising privileges. We determined that this addressed the previously identified area for improvement 4 as outlined in section 6.2.

6.5.4 User rights agreements

On 23 January 2020 we received written confirmation from Ms Carmichael that the practice of granting user rights to AHPs had ceased with immediate effect. During this inspection we reviewed the arrangements for granting practising privileges for AHPs and were satisfied that robust arrangements were in place. We confirmed that the same practising privileges system is in place for AHPs as for medical practitioners. We determined that this addressed the previously identified area for improvement 5 as outlined in section 6.2.

6.5.5 Patient records

We confirmed that the CGO had undertaken audits of medical records. We reviewed audit reports dated August 2020 and February 2021 and evidenced that an action plan with a named person responsible for taking forward identified actions and corresponding timescales had been generated as a result of these audits. We confirmed that these audit reports had been shared with the MAC and Responsible Individual. We suggested during the previous inspection of NWIH that the RMO's could be utilised to undertake audits of medical notes and we would like to reinforce this suggestion.

We determined that this addressed the previously identified area for improvement 6 as outlined in section 6.2.

6.5.6 Quality assurance

The hospital has developed a rolling audit programme that has been ratified by the MAC in August 2020. We met with the CGO who provided evidence that audits are undertaken on a monthly basis and three monthly analyses of the findings are undertaken to identify trends and compare results with previous audits. Where applicable, action plans are developed that include the named person responsible for addressing the required actions and any corresponding timescales.

The results of audits and the action plans are shared monthly with the Responsible Individual and quarterly with the MAC and the relevant committees within the hospital's governance structures. The CGO told us that they are benchmarking the outcomes of handwashing audits with another independent hospital and outlined the plans to further expand this in relation to other audits as the programme develops. We found evidence of audits findings being appropriately shared with staff across the various departments within the hospital. We determined that this addresses the previously identified area for improvement 7 as outlined in section 6.2.

We met with a quality management consultant who described plans to implement a new digital quality management system for the hospital. The digital platform will be available to all staff, as relevant to their roles and responsibilities, and will contain information regarding alerts, audits, complaints, incidents, key performance indicators (KPIs), near misses, and never events. The information will be displayed in a dashboard format for ease of viewing. The new system when launched will be able to provide live data analytics to the relevant governance committees which will enhance and strengthen the overall governance structures.

6.5.7 Staffing

All staff spoken we engaged with during this inspection told us that they had an annual appraisal during the previous twelve calendar months. We determined that this addresses the previously identified area for improvement 8 as outlined in section 6.2

6.5.8 Central Sterile Servicing Department (CSSD)/endoscopy arrangements

On 18 January 2021 a training certificate confirming that the identified staff member had completed an Authorised Person (Decontamination) AP (D) course between 12 and 15 October 2020 was submitted to RQIA. We determined that this addressed the previously identified area for improvement 9 as outlined in section 6.2.

6.5.9 Medicines management

This area for improvement was validated remotely by a pharmacist inspector following the inspection. We found that monthly Kardex auditing had been established by the hospital's pharmacist and copies of the three most recent audit reports were examined. These provided a comprehensive assessment of the Kardexes reviewed and information on the areas to be addressed. A retrospective analysis of medicines reconciliation was also provided, including a summary report and action plan. It was confirmed that the resulting action plans from both of these audits were discussed with the Registered Manager and shared with the MAC. We determined that this addressed the previously identified area for improvement 11 as outlined in section 6.2.

6.5.10 Resuscitation and management of medical emergencies

We evidenced that a risk assessment was undertaken with respect to the provision of medical emergency medicines and equipment in the outpatient department. This risk assessment had been ratified by the MAC. We reviewed the emergency medicines and equipment available in the treatment room in the outpatient department. We confirmed that robust arrangements were in place to check the expiry dates of these emergency medicines and equipment. We determined that this addressed the previously identified area for improvement 12 as outlined in section 6.2.

6.5.11 Environment

We reviewed the IPC policy dated March 2020 and noted that the information, in relation to flagging a patient's infection risk is embedded into practice, recorded and communicated with all relevant departments, specified within the previously identified area for improvement 13 had not been included within this policy. We noted the policy was in keeping with The Northern Ireland Regional Infection Prevention and Control Manual. We were informed that this information had been specified within the Methicillin-resistant Staphylococcus aureus (MRSA) policy. However, this information should be specified within the main IPC policy as a patient's infection risk is not exclusive to MRSA and could relate to other infective illnesses. This area for improvement has been assessed as not met and has been stated for a second time.

6.5.12 Care pathway

We were informed that the nursing tools currently used across the hospital had been reviewed to ensure that they were up to date and in line with best practice guidance. The tools that required to be updated were identified as the National Early Warning Scores (NEWS) and the Paediatric Early Warning Scores (PEWS). Discussion with staff confirmed that they were using the current NEWS and PEWS, which had been implemented in September 2020. We reviewed a selection of training records and found that training on the completion of NEWS and PEWS had been provided to the relevant staff. Compliance with the NEWS and PEWS tools is audited as part of the hospital's rolling audit programme. We determined that this addressed the previously identified area for improvement 14 as outlined in section 6.2.

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. Discussion with staff confirmed that they were aware of the admission process and applicable care pathways. Many areas of good practice were identified with respect to the care delivered. We observed staff on both wards engaging positively with patients. Copies of the patient guide are made available to all patients following admission.

6.5.13 Staffing

The Human Resources (HR) Manager told us that two individuals external to NWIH had been appointed to undertake a cultural assessment. These individuals held one to one interviews with the SMT, heads of department and various staffing groups. We reviewed the report generated following the cultural assessment and found that this included an action plan to address the issues identified. We confirmed that the recommendations within the report had been actioned, such as facilitating leadership training, and that the report had been presented to Mr Stewart, Responsible Individual. The report identified 'significant strengths in relation to NWIH management culture and working environment'. We determined that this addressed the previously identified area for improvement 15 as outlined in section 6.2.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mc Carmichael, Registered Manager, as part of the inspection process. The timescales for 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 action. It is the responsibility of the Registered Provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

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

7.1 Areas for improvement

Areas for improvement have been identified in which 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 the 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)	
Area for Improvement 1 **Ref: Standard 20.2** **Stated: Second time** **To be completed by:** 15 April 2020	The Registered Persons shall ensure that the arrangements specified in the hospital's IPC policy in relation to flagging a patient's infection risk is embedded into practice, including how this is recorded and communicated through the various departments. When the IPC policy is amended or further developed in this regard the refreshed policy must be in accordance with The Northern Ireland Regional Infection Prevention and Control Manual. Ref: 6.2
	Response by registered person detailing the actions taken: We can confirm that arrangements in the hospital's IPC policy for flagging a patient's infection risk is embedded into practice and

	includes how this is recorded and shared between the various departments. This has been completed in accordance with the Northern Ireland Regional Infection Prevention & Control Manual which is available to all staff.
Area for improvement 2 **Ref:** Regulation 18 (4) **Stated:** First time **To be completed by:** 20 May 2021	The registered persons shall ensure that the induction programme for Resident Medical Officers (RMO's) includes details of the hospital's medical governance structures and the arrangements for the day to day management and supervision of the RMO's clinical practice. The management arrangements for RMO's should be clearly visible within the hospital's governance structures. Ref: 6.5.3
	Response by registered person detailing the actions taken: We can confirm that the induction programme for the Resident Medical Officers includes the hospital's medical governance structures and arrangements for the day to day management and supervision of the RMO's clinical practice.
Area for improvement 3 **Ref:** Standard 48.21 **Stated:** First time **To be completed by:** **20 May 2021**	The registered person shall seek advice from their laser protection advisor (LPA) to amend the laser safety policy to provide an overarching statement on the approach to laser safety, making reference to the existence of Local Rules and the medical treatment protocols. Ref: 6.4.1
	Response by registered person detailing the actions taken: The laser protection advisor(LPA) has provided an overarching statement that identifies the approach to laser safety, with reference to the existence of Local Rules and the medical treatment protocols.
Area for improvement 4 **Ref**: Standard 48.19 **Stated:** First time **To be completed by:** 20 May 2021	The registered person shall provide a policy for the safe storage of the laser key to be shared with all relevant staff and retained in the laser safety file. Ref: 6.4.1
	Response by registered person detailing the actions taken: We can confirm that there is a policy for the safe storage of the laser key and the policy has been shared with the relevant staff as identified in the laser safety file.

26th March 2021

Mr Stephen O'Connor / Ms Carmel McKeegan
Regulation & Quality Improvement Authority
9th Floor
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5 Lanyon Place
Belfast
BT1 3BT

Dear Stephen & Carmel

Laser Protection Report

North West Independent Hospital, Church Hill House, Ballykelly BT49 9HS

Introduction

Further to the inspection of the above premises on 25th March 2021 this report summarises the main laser protection aspects where action may be required. The findings are based on the requirements of current legislation, relevant guidance notes and European Standards.

Deficiencies & Comments

(1) Servicing of Laser
The Promed Service test report of March 2020 states that the next service was due in March 2021, however this has not been carried out. Due to other workload NWIH are not currently using the laser, however a service should be arranged before further laser sessions are scheduled.

(2) Local Rules
Section 7 of the Local Rules refer to Protective Eyewear with a minimum rating of 1400LB2. This is probably a typographical error as the laser output occurs at 1470nm, so the clinic should bring this to the attention of their LPA.

The Local rules currently refer to a safe systems for storage of the keys to switch on the laser. Further details of the safe storage arrangements should be detailed in the Local Rules.

(3) Review of Treatment Protocol
The NWIH's review timetable states that the Treatment Protocol dated 10/12/19 should have been reviewed in December 2020. This review should be carried out before the next session of laser treatments are booked.

(4) Assisting Staff
Included in the list of staff who have signed a declaration stating that they have read and understood the Local Rules is a group currently identified as 'non clinical users'. As this group of staff do not 'use' the laser this group should be renamed as 'assisting staff'.

(5) General Policy 23 – Use of Lasers within NWIH
Large sections of this document are a duplicate of the Local Rules. NWIH should seek advice from their LPA to amend this document to provide an overarching statement on the approach to laser safety making reference to the existence of Local Rules and Treatment Protocols.

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Dr Ian Gillan
Laser Protection Adviser to RQIA

Appendix 1

North West Independent Hospital, Church Hill House, Ballykelly BT49 9HS

Laser

Equipment description:	Endovenous Laser Therapy (EVLT) Ga As diode laser
Manufacturer:	Ceramoptec Biolitec
Model:	Ceralas E
Class:	4
Wavelength:	1470nm
Serial no:	4291G

Laser Protection Adviser

Mr Philip Loan, Onephoton

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