Announced Inspection

Name of Establishment:	**North West Independent Hospital**
Establishment ID No:	**10624**
Date of Inspection:	**15 October 2014**
Inspectors' Names:	**Jo Browne and Winnie Maguire**
Inspection No:	**17420**

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 General Information

Name of establishment:	North West Independent Hospital
Address:	Church Hill House Ballykelly BT49 9HS
Telephone number:	028 8777 63090
Registered organisation/ registered provider:	North West Independent Hospital Mr Philip Stewart
Registered manager:	Miss Finola Carmichael
Person in charge of the establishment at the time of inspection:	Miss Finola Carmichael
Registration categories:	AH – Acute Hosptials (with overnight beds) PT(E) - Prescribed techniques or prescribed technology: establishments using endoscopy PT(L) - Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers
Registered beds:	35 Inpatient beds 13 Day case beds
Date and time of inspection:	15 October 2014 10.35 – 17.15
Date and type of previous inspection:	Follow up 27 November 2013
Names of inspectors:	Jo Browne Winnie Maguire

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect independent health care establishments. A minimum of one inspection per year is required.

This is a report of the announced inspection to assess the quality of services being provided. The report details the extent to which the regulations and DHSPPS Minimum Care Standards for Independent Healthcare Establishments, July 2014, measured during the inspection were met.

2.1 Purpose of the Inspection

The purpose of this inspection was to ensure that the service is compliant with relevant regulations, the minimum standards and to consider whether the service provided to patients was in accordance with their assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, procedures, practices and monitoring arrangements for the provision of an independent hospital, and to determine the provider's compliance with the following:

- The HPSS (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
- The Department of Health, Social Services and Public Safety's (DHSSPS) Minimum Care Standards for Independent Healthcare Establishments

Other published standards which guide best practice may also be referenced during the inspection process.

2.2 Methods/Process

Committed to a culture of learning, RQIA has developed an approach which uses self-assessment, a critical tool for learning. The self-assessment was forwarded to the provider prior to the inspection and was reviewed by the inspectors prior to the inspection. The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspectors.

Specific methods/processes used in this inspection include the following:

- Analysis of pre-inspection information and self-assessment
- Discussion with the registered manager, Ms Finola Carmichael
- Discussion with the chief executive, Mrs Liz Dallas
- Discussion with the theatre manager
- Discussion with the clinical governance lead
- Discussion with staff
- Examination of records
- Consultation with patients
- Tour of the premises
- Evaluation and feedback

Any other information received by RQIA about this registered provider and its service delivery has also been considered by the inspectors in preparing for this inspection.

The completed self-assessment is appended to this report.

2.3 Consultation Process

During the course of the inspection, the inspectors spoke with the following:

Patients	4
Patients' representatives	3
Staff	6

2.4 Inspection Focus

The inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Minimum Care Standards for Independent Healthcare Establishments and to assess progress with the issues raised during and since the previous inspection.

- Standard 5 Patient and Client Partnerships
- Standard 6 Care Pathway
- Standard 7 Complaints
- Standard 9 Clinical Governance
- Standard 16 Management and Control of Operations
- Standard 31 Resuscitation
- Standard 32 Surgery

3.0 Profile of Service

Opened in 1989, the North West Independent Hospital is situated in the village of Ballykelly, approximately twenty minutes from the City of Londonderry. The hospital is close to local amenities and public transport routes. Due to its location the hospital is easily accessible for patients coming from the Republic of Ireland.

The hospital is registered for 35 beds and provides a wide range of services and treatments, ranging from outpatient medical and surgical consultations, diagnostic tests and investigations, simple surgical day case procedures and paediatric services to major surgical interventions such a joint replacement surgery. In March 2013 the hospital registered a 13 bedded day case unit.

The hospital is accessible for patients with a disability.

Private car parking is available for patients and visitors within the grounds of the hospital.

The North West Independent Hospital is registered as an acute hospital with overnight beds, day procedure beds, prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers and prescribed techniques or prescribed technology: establishments using endoscopy categories of registration.

Ms Finola Carmichael has been the registered manager since 6 April 2011.

4.0 Summary of Inspection

An announced inspection was undertaken by Jo Browne and Winnie Maguire on 15 October 2014 from 10.35 to 17.15. The inspection sought to establish the compliance being achieved with respect to 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 DHSPPS Minimum Care Standards for Independent Healthcare Establishments.

There were no requirements or recommendations made as a result of the previous follow up inspection on 27 November 2013.

The inspection focused on the DHSPPS Minimum Care Standards for Independent Healthcare Establishments outlined in section 2.4 of this report.

At the time of this inspection a simultaneous review of theatre practices was being undertaken by a separate team of RQIA inspectors. A copy of the review report will be forwarded separately to the hospital and made available on the RQIA website.

Mrs Liz Dallas and Ms Finola Carmichael were available during the inspection and for verbal feedback at the conclusion of the inspection.

During the course of the inspection the inspectors discussed operational issues, examined a selection of records and carried out a general inspection of the hospital.

There are robust systems in place to obtain the views of patients. The inspectors reviewed a sample of 100 completed patient questionnaires, along with the summary report and found that patients were highly satisfied with the quality of care and treatment provided. Comments received from patients can be viewed in the main body of the report. Feedback from patients is used by the management of the hospital to improve patient services.

Patients are provided with a comprehensive information pack prior to their admission which outlines any pre-operative requirements, post-operative instructions and the arrangements for admission to the establishment.

The inspectors reviewed the care records of four patients undergoing surgery and found them to be well completed. There was a clear pathway of care recorded from the initial consultation, to informed consent, to admission, through pre-operative care, intra-operative care, post-operative care, review and discharge.

A discharge letter summarising the patient's treatment and care is sent to the patient's general practitioner (GP) and any other relevant professionals who are involved in ongoing care and treatment, with the consent of the patient.

The hospital's complaints policy and procedure is in line with the DHSSPS guidance and legislation. The inspectors reviewed complaints management within the establishment and found that complaints were well documented, fully investigated and had outcomes recorded.

The registered manager is responsible for the day to day running of the establishment and ensuring compliance with the legislation and standards.

The hospital has developed and implemented comprehensive clinical governance systems to audit and monitor the quality of clinical care provided. They have also appointed a clinical governance lead nurse, developed a two year clinical governance strategy and annual clinical audit schedule, which is to be commended. The inspectors reviewed audits and quality of clinical care indicators as outlined in the main body of the report.

The registered provider is involved the running of the establishment and would be present be in the hospital on a regular basis. It was recommended that formal minutes are retained of all meetings with the registered provider.

The inspectors reviewed incident management and found that incidents were well documented, fully investigated and had outcomes recorded. Audits of incidents were undertaken as part of the hospital's clinical governance systems. Arrangements were in place to disseminate learning outcomes throughout the organisation.

The registered manager confirmed that no research is currently being undertaken within the hospital.

There is a defined management structure within the hospital and clear lines of accountability.

The inspectors reviewed the policy and procedures in relation to the absence of the registered manager and whistle blowing. A recommendation was made to update the absence of the registered manager policy to reflect current management arrangements within the hospital.

The registered manager undertakes ongoing training to ensure that they are up to date in all areas relating to the provision of services.

A Statement of Purpose and Patient Guide were in place which reflected legislative and best practice guidance.

The inspectors spoke with a member of the catering staff, reviewed menus and confirmed that appropriate meals are provided in line with the assessed needs of the patients.

The registered manager confirmed that no agency staff are used within the hospital.

The inspectors reviewed the insurance arrangements for the hospital and found that current insurance policies were in place.

There is a written resuscitation policy in place. Staff had received basic life support training and updates. There is always at least one staff member with advanced life support training on duty at all times. Staff involved in the provision of paediatric care have paediatric life support training and updates. When children are admitted for

treatment there is at least one staff member on duty trained in paediatric advanced life support.

There is a range of resuscitation equipment in place which is checked and restocked to ensure all equipment remains in working order and is suitable for use at all times. The inspectors reviewed the contents of the resuscitation trolley in the inpatient ward area and found that is contained all the required equipment and medication.

The establishment has a range of policies and procedures for surgical procedures which are in accordance with good practice guidelines and national standards.

The scheduling of patients is co-ordinated by theatre manager with the assistance of administration staff. The theatre lists take into account the individual requirements of the patient, the type of procedure to be undertaken, equipment required, associated risks and the level of sedation used.

The inspectors did not undertake a review of the theatre environment during this inspection due to the ongoing theatre review however they met and spoke with the theatre manager.

The inspectors met with the theatre manager and discussed staffing levels. The theatres were found to have adequate staffing levels to meet the individual needs of the patients undergoing surgery. The inspectors also discussed intra-operative fluid management, the identification of the theatre team leader, the completion of the WHO checklist and roles and responsibilities of the theatre team with the theatre manager. A recommendation was made to develop robust policies and procedures for the management of intra-operative fluids. The inspectors provided guidance on the areas which should be included in the policies and procedures. The theatre manager informed the inspectors that advice could be sought from the medical advisory committee for the completion of this task.

The theatre manager confirmed there is an identified senior member of nursing staff (team leader), with theatre experience, in charge of the operating theatre at all times. A permanent record of the team leader for each theatre is retained.

The inspectors confirmed that the surgical checklist based on the World Health Organisation (WHO) model is used in the hospital. The inspectors reviewed completed surgical checklists within the patients' care records.

The inspectors were informed the anaesthetist is present throughout the operation and is present onsite until the patient has recovered from the immediate effects of the anaesthetic.

Equipment, installations and facilities are in place to provide the services outlined in the hospital's Statement of Purpose. The theatre manager confirmed there are systems in place to ensure that theatre equipment is maintained and decontaminated in line with the manufacturers' guidelines.

Overall, on the day of inspection, the establishment was found to be providing a quality, safe and effective service to patients.

The certificates of registration and insurance were clearly displayed in the reception area of the hospital.

There were three recommendations made as result of this inspection. These are discussed fully in the main body of the report and in the appended Quality Improvement Plan.

The inspectors would like to thank Mrs Dallas, Ms Carmichael, patients and staff of the North West Independent Hospital for their hospitality and contribution to the inspection process.

5.0 Follow Up on Previous Issues

No requirements or recommendations were made as a result of the previous inspection.

6.0 Inspection Findings

STANDARD 5	
Patient and Client Partnerships:	**The views of patients and clients, carers and family members are obtained and acted on in the evaluation of treatment, information and care**

North West Independent Hospital obtains the views of patients on a formal and informal basis as an integral part of the service they deliver.

The establishment issues feedback questionnaires to patients following treatment. The inspectors reviewed a random selection of 100 completed questionnaires and found that patients were highly satisfied with the quality of treatment, information and care received. Comments received on the feedback questionnaires included:

- "The care in the hospital is second to none. I highly recommend it. Sincere thanks to everyone"
- "Hospital staff were excellent, very attentive and caring"
- "No complaints, well done to all"
- "Very good hospital. Was very well looked after. Staff was very welcoming and kind"
- "Excellent and friendly staff"
- "Keep up the good work"
- "Friendly and caring group of people who are very professional doing their job"
- "From start to finish every member of staff have been excellent and a credit to their profession"
- "Sets a benchmark for all hospitals"
- "Couldn't be better"
- "Everything well explained"
- "Excellent, quality care"

The information received from the patient feedback questionnaires is collated into an annual summary report which is made available to patients and other interested parties to read within the Patient Guide and Statement of Purpose.

The inspectors suggested that the Patient Guide and Statement of Purpose could contain the arrangements for accessing the summary report of the patient feedback questionnaires instead of the full report to future-proof these documents. They also discussed including the summary report on the hospital's website.

The inspectors met with four patients and three relatives during the course of the inspection who felt that their views and opinions were valued by the hospital.

Evidenced by:

Review of patient satisfaction surveys
Review of summary report of patient satisfaction surveys
Summary report made available to patients and other interested parties
Discussion with patients and/or their representatives
Discussion with staff

STANDARD 6	
Care Pathway:	**Patients and clients have a planned programme of care from the time of referral to a service through to discharge and continuity of care is maintained.**

Patients are 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.

The establishment has a wide range of information leaflets available regarding the types of procedures available. The registered manager confirmed that information can be provided in an alternative language or format if required.

The inspectors spoke with four patients who all confirmed that they had received comprehensive information prior to their admission and from the multi-disciplinary team following their admission.

A range of clinical assessments are undertaken by the different members of the health care team prior to surgery and the outcomes are recorded in the individual patient care records. Systems are in place to refer patients to specialist services to meet the assessed needs of the patients, e.g. physiotherapy and occupational therapy.

The inspectors reviewed the care records of four patients and found that the care records contained comprehensive information relating to pre-operative, intra-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 (WHO)
- 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
- Discharge plan

Discussion with patients and review of the care records confirmed that patients are involved in planning their care and treatment.

The inspectors advised the hospital to evidence the involvement of patients in planning their care within the care records.

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

Comments received from patients regarding their stay in the hospital included:

- "First class"
- "Staff 100%"
- "Very helpful and explained everything"
- "Very clean and very good domestic"
- "I received written information in a booklet and excellent care"
- "Food was excellent"
- "Food good"
- "First class service"
- "No issues"
- "Everyone courteous and polite"

Patients and staff confirmed that the results of investigations and treatment provided are explained. Future treatment options are discussed and patients are involved in the decision making process.

A planned discharge programme is in place that provides the patient with information on the future management of their condition, supply of medication, liaison with community services, follow up advice and support including what to do in the event of a complication or problem.

Arrangements are in place to ensure that children and young people are discharged from the hospital as soon as their condition allows and when ongoing care can be provided at home. Most children attending the hospital are treated as day cases.

A discharge letter summarising the patient's treatment and care is sent to the patient's general practitioner (GP) and any other relevant professionals who are involved in ongoing care and treatment. The information provided on discharge to the patient and community services has been reviewed and updated, particularly in relation to wound care management and post-operative infection.

Evidenced by:

Review of patient care records
Discussion with patients and/or their representatives
Discussion with staff

Discharge plan and letter to GP or other relevant professionals

STANDARD 7	
Complaints:	**All complaints are taken seriously and dealt with appropriately and promptly.**

The establishment operates a complaints policy and procedure in accordance with the DHSSPS guidance on complaints handling in regulated establishments and agencies and the legislation. The registered provider/manager demonstrated a good understanding of complaints management.

All patients are provided with a copy of the complaints procedure, which is contained within the patient guide and statement of purpose. The registered manager confirmed that the complaints procedure could be made available in alternative formats and languages if required.

The inspectors reviewed the complaints register and complaints records. All complaints were well documented, fully investigated and had outcomes recorded in line with the complaints procedure and legislation.

The clinical governance lead undertakes an audit of complaints. The audit information is used to identify trends and enhance services provided as part of the hospital's clinical governance arrangements.

Patients who met with the inspectors confirmed that they had been made aware of how to raise a complaint; however they had no concerns regarding the quality of care provided and were very complimentary regarding the hospital and staff.

Evidenced by:

Review of complaints procedure
Complaint procedure made available to patients and other interested parties
Discussion with patients and/or their representatives
Discussion with staff
Review of complaints records
Review of the audit of complaints

STANDARD 9	
Clinical Governance:	**Patients and clients are provided with safe and effective treatment and care based on best practice guidance, demonstrated by procedures for recording and audit.**

Ms Carmichael ensures the establishment delivers a safe and effective service in line with the legislation, other professional guidance and minimum standards.

The establishment have reviewed their clinical governance systems and implemented robust arrangements to audit the quality of service provided and drive service improvement. To facilitate this process the hospital have appointed a clinical governance lead nurse who met with the inspectors and outlined the comprehensive arrangements in place.

Discussion with Ms Carmichael, Mrs Dallas, the clinical governance lead and review of training records confirmed that systems are in place to ensure that staff receive appropriate training when new procedures are introduced.

The hospital has developed a comprehensive clinical governance strategy for 2014 – 2016 and an annual clinical audit schedule, which is to be commended.

The inspectors reviewed a sample of the following audits from the clinical audit schedule as part of the inspection process:

- Patient satisfaction questionnaires
- A range of clinical theatre audits
- Post-operative wound infection audit
- Patient personal medication audit
- Care plans and evaluation audit
- Consent forms completeness audit
- Infection prevention and control audit
- Audit of National Patient Safety Agency (NPSA) recommendations regarding hypnonatraemia in children
- Audit of the NPSA recommendations regarding haemovigilance
- Incidents audit
- Sharps box audit
- Hand washing audit
- Completion of fluid balance chart audit (adult and paediatric)
- Audit of patient following discharge who had received joint replacements

The clinical governance lead informed the inspectors that the hospital are undertaking benchmarking exercises against other similar sized hospitals in Ireland and hope to establish similar links with hospitals in England.

The registered provider is involved the running of the establishment and would be present be in the hospital on a regular basis. It was recommended that formal minutes are retained of all meetings with the registered provider.

There are clear arrangements for monitoring the quality of clinical care that include the following indicators:

- Unplanned returns to theatre
- Peri-operative deaths
- Unplanned re-admissions to hospital
- Unplanned transfers to other hospitals
- Adverse clinical incidents
- Post-operative infection rates for the hospital

The establishment has an incident policy and procedure in place which includes reporting arrangements to RQIA. Following the previous inspection the hospital has further developed their incident management and had developed a comprehensive investigation template for the post-operative infections.

The inspectors reviewed incident management and found that incidents were well documented, fully investigated and had outcomes recorded.

Audits of incidents are undertaken quarterly and learning outcomes are identified and disseminated throughout the organisation.

The registered manager confirmed that no research is currently being undertaken within the hospital. Ms Carmichael also confirmed before any research involving patients would be considered a research proposal would be prepared and approval obtained from the appropriate Research Ethics Committee (REC).

Evidenced by:

Review of policies and procedures
Review of training records
Discussion with registered manager
Discussion with clinical governance lead
Review of monitoring reports
Review of audits
Review of incident management
Review of research arrangements

STANDARD 16	
Management and Control of Operations:	**Management systems and arrangements are in place that ensure the delivery of quality treatment and care.**

There is a defined organisational and management structure that identifies the lines of accountability, specific roles and details responsibilities for all areas of the service.

The establishment has a policy and procedure in place to ensure that RQIA is notified if the registered manager is absence for more than 28 days. The policy includes the interim management arrangements for the establishment. A recommendation was made to ensure that the policy reflected the current management arrangements within the hospital.

Review of the training records and discussion with the registered manager confirmed that they undertake training relevant to their role and responsibilities within the organisation.

The inspectors reviewed the establishment's Patient Guide and Statement of Purpose and found them to be in line with the legislation.

The inspectors confirmed that appropriate meals are provided in line with the assessed needs of the patients. The inspectors reviewed menus and met with a member of the catering staff who confirmed arrangements are in place to notify the kitchen of any special dietary requirements. In-patients are offered a choice of meals, including vegetarian, healthy options and special diets. Patients confirmed that the food provided was of an excellent standard. Day case patients are offered light refreshments prior to discharge.

Mrs Dallas confirmed that no agency staff are used within the hospital as the hospital have recruited their own bank staff.

There is a written policy on "Whistle Blowing" and written procedures that identify to whom staff report concerns about poor practice and the support mechanisms available to those staff.

The inspectors discussed the insurance arrangements within the establishment and confirmed current insurance policies were in place. The certificates of registration and insurance were clearly displayed in the reception area of the premises.

Evidenced by:

Review of policies and procedures
Review of training records
Review of Patient Guide
Review of Statement of Purpose
Review of arrangements for meals
Review of insurance arrangements

STANDARD 31	
Resuscitation:	**Resuscitation equipment is readily accessible and resuscitation is carried out by trained competent staff and in line with the Statement of Purpose.**

There is a written resuscitation policy in place which was found to be in line with the Resuscitation Council (UK) guidelines.

Staff had received basic adult life support training and updates. There is always at least one staff member with advanced life support training on duty at all times. Ms Carmichael informed the inspectors that two ward staff and the resuscitation officer who is an Operating Department Practitioner (ODP) had recently completed advanced life support training.

Staff involved in the provision of paediatric care have paediatric life support training and updates. The inspectors noted that the paediatric life support training was due to be updated and Ms Carmichael informed them that arrangements had been made to address this. When children are admitted for treatment there is at least one staff member on duty trained in paediatric advanced life support.

The inspectors discussed arrangements regarding patients with a "Do Not Resuscitate" (DNR) order in place. Ms Carmichael confirmed that patients who would have a DNR order in place would not meet the normal admission criteria for elective surgery within the hospital.

There is a range of resuscitation equipment in place in the inpatient ward area and theatre recovery.

Equipment for resuscitating patients includes:

- A charged defibrillator and ECG monitor
- Portable oxygen with appropriate valves, mask, metering and delivery system
- First line resuscitation medication
- Equipment for maintaining and securing the airway of a patient
- Equipment to insert and maintain intravenous infusions
- Latex free alternative equipment
- Paediatric intubation tray where children are treated
- Paediatric first line resuscitation equipment and medication

Resuscitation equipment is checked and restocked to ensure all equipment remains in working order and suitable for use at all times. The inspectors reviewed the contents of the resuscitation trolley in the inpatient ward area and found that it contained all of the required equipment and medication. A record of all equipment and drugs is attached to the resuscitation trolley and a written record is retained of the daily checks.

Resuscitation equipment is cleaned and decontaminated following use.

Evidenced by:

Review of resuscitation policy and procedure
Review of records of resuscitation equipment and checks
Review of resuscitation equipment
Review of resuscitation training
Review of paediatric resuscitation procedures, equipment and medication

STANDARD 32	
Surgery:	**There are arrangements in place to support the provision of safe and effective surgical practices.**

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland.

RQIA's reviews and inspections are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest.

In the first quarter of 2013 RQIA undertook a thematic review of theatres, the review was commissioned by DHSSPS and scheduled within the RQIA three year review programme for 2012 to 2015. In November 2013 a decision was made to undertake similar inspections in relevant independent hospitals. An inspection was carried out by a team of RQIA inspectors to review aspects of theatre practice simultaneously with this inspection. A separate review report will be forwarded to the hospital and made available on the RQIA website.

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

Within the hospital there is a defined staff structure for surgical services which clearly outlines areas of accountability and individual roles and responsibilities.

The scheduling of patients for surgical procedures is co-ordinated by the theatre manager with the assistance of administration 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 and level of sedation used.

The inspectors did not undertake a review of the theatre environment during this inspection due to the ongoing theatre review however they met and spoke with the theatre manager.

The inspectors met with the theatre manager to discuss staffing levels. The theatres were found to have adequate staffing levels to meet the individual needs of the patients undergoing surgery.

There is an identified senior member of nursing staff (team leader), with theatre experience, in charge of the operating theatre at all times. A permanent record of the team leader for each theatre is retained.

The inspectors confirmed that the surgical checklist based on the World Health Organisation (WHO) model is used in the hospital. The inspectors reviewed completed surgical checklists within the patients' care records.

Prior to surgery, the inspectors confirmed, that patients receive verbal and written pre-operative information on:

- Fasting
- Taking of existing medication
- Arrangements for escort to and from theatre

Review of the patient care records and discussion with staff and patients confirmed that the anaesthetist who gives 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
- discuss options for post-operative pain relief

The inspectors were informed the anaesthetist is present throughout the operation and is present onsite until the patient has recovered from the immediate effects of the anaesthetic.

The inspectors discussed intra-operative fluid management, the identification of the theatre team leader, the completion of the WHO checklist and roles and responsibilities of the theatre team with the theatre manager. A recommendation was made to develop robust policies and procedures for the management of intra-operative fluids. The inspectors provided guidance on the areas which should be included in the policies and procedures. The theatre manager informed the inspectors that advice could be sought from the medical advisory committee for completion of this task.

Patients are provided with written post-operative instructions relevant to their individual procedure which includes:

- Pain relief
- Bleeding
- Care of the post-operative site
- The potential effects of anaesthesia

Equipment, installations and facilities are in place to provide the services outlined in the hospital's Statement of Purpose. The theatre manager confirmed there are systems in place to ensure that theatre equipment is maintained and decontaminated in line with the manufacturers' guidelines.

Evidenced by:

Discussion with theatre manager
Discussion with staff
Discussion with patients

7.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Liz Dallas and Ms Finola Carmichael as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider / manager is required to record comments on the Quality Improvement Plan.

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

Enquiries relating to this report should be addressed to:

Jo Browne
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Quality Improvement Plan

Announced Inspection

North West Independent Hospital

15 October 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Liz Dallas and Ms Finola Carmichael either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

RECOMMENDATIONS

These recommendations are based on the DHSPPS Minimum Care Standards for Independent Healthcare Establishments, research or recognised sources. They promote current good practice and if adopted by the registered person/manager may enhance service, quality and delivery.

NO.	MINIMUM STANDARD REFERENCE	RECOMMENDATIONS	NUMBER OF TIMES STATED	DETAILS OF ACTION TAKEN BY REGISTERED PERSON(S)	TIMESCALE
1	9.5	The registered manager should ensure that minutes are retained of all meetings with the registered provider. **Ref: Standard 9**	One	Quality of Service Monitoring form is completed by the registered person on a monthly basis and has been commenced 04/11/2014 for October 2014 (See attached form).	Immediately and ongoing
2	16.3	The registered manager should ensure that the absence of registered manager policy is updated to reflect the current management arrangements within the hospital. **Ref: Standard 16**	One	"The absence of the Registered Manager Policy" has been updated to reflect the current management arrangements within the Hospital.	Within one month
3	32.1	The registered manager should ensure that robust policies and procedures are developed for the management of intra-operative fluids. **Ref: Standard 32**	One	Robust policy and procedure for the management of Intra-operative fluids is currently being developed.	Within three months

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person and return to independent.healthcare@rqia.org.uk

Name of Registered Manager Completing QIP	Miss Finola Carmichael
Name of Responsible Person / Identified Responsible Person Approving QIP	Mr Phillip Stewart

QIP Position Based on Comments from Registered Persons		**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Jo Browne	11/11/14
Further information requested from provider	No	Jo Browne	11/11/14

The Regulation and Quality Improvement Authority

Pre-Inspection Self-Assessment Independent Hospital

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THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect independent health care establishments. A minimum of one inspection per year is required.

The aim of inspection is to examine the policies, procedures, practices and monitoring arrangements for the provision of an independent hospital, and to determine the provider's compliance with the following:

- The HPSS (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
- The Department of Health, Social Services and Public Safety's (DHSSPS) Minimum Care Standards for Independent Healthcare Establishments July 2014

Other published standards which guide best practice may also be referenced during the inspection process.

2.0 Self-Assessment

Committed to a culture of learning, RQIA has developed an approach which uses self-assessment.

Where asked in the self-assessment you are required to indicate a yes or no response. You are also asked to provide a brief narrative in the "text box" where applicable.

Following completion of the self-assessment, please return to RQIA by the date specified.

The self-assessment will be appended to the report and made available to the public. No amendments will be made by RQIA to your self-assessment response.

3.0 Self-Assessment Tool

Management of Operations

	YES	NO
Has any structural change been made to the premises since the previous inspection?		NO
Have any changes been made to the management structure of the hospital since the previous inspection?	YES	
Yes, please comment The appointment of Clinical Governance and Infection Prevention Control Advisor. - Miss Shirley Baird Jan 2014		

Policies and Procedures

	YES	NO
Does the hospital have a policy and procedure manual in place which is reviewed at least every 3 years or as changes occur?	YES	
Are the policies and procedures for all operational areas in line with legislation and best practice guidelines?	YES	
Do all policies and procedures contain the date of issue, date of review and version control?	YES	
Are all policies and procedures ratified by the registered person?	YES	
No, please comment + signed off by the Hospital Director		

Records Management

	YES	NO
Does the hospital have a policy and procedure in place for the creation, storage, transfer, retention and disposal of and access to records in line with the legislation?	YES	
Are care records maintained for each individual patient?	YES	
Do the care records reflect the patient pathway from referral to discharge?	YES	
Are arrangements in place to securely store patient care records?	YES	
No, please comment		

Patient Partnerships

	YES	NO
Does the hospital have systems in place to obtain the views of patients regarding the quality of treatment, care and information provided?	YES	
Does the hospital make available a summary report of patient feedback to patients and other interested parties?	YES	
No, please comment		

Resuscitation

	YES	NO
Does the hospital have a resuscitation policy and procedure in place which is in line with the Resuscitation Council (UK) guidance?	YES	
Is resuscitation equipment readily accessible in all clinical areas?	YES	
Are arrangements in place to ensure resuscitation equipment is checked regularly and restocked to ensure all equipment remains in working order and suitable for use at all times?	YES	
Is there at least one person with advance life support training on duty at all times?	YES	
Where children are admitted for treatment, is there at least one person with paediatric advanced life support training on duty at all times?	YES	
No, please comment		

Safeguarding

	YES	NO
Does the hospital have a protection of vulnerable adults policy and procedure in place which is in line with the legislation and regional guidance?	YES	
Does the hospital have a safeguarding children policy and procedure in place which is in line with the legislation and regional guidance?	YES	
Does the hospital have a whistle-blowing policy and procedure in place?	YES	
No, please comment		

Complaints

	YES	NO
Does the hospital have a complaints policy and procedure in place which is in line with the legislation and the DHSSPS guidance on complaints handling in regulated establishments and agencies April 2009?	YES	
Are all complaints documented, fully investigated and have outcomes recorded in line with the legislation and the hospital's complaints policy and procedure?	YES	
No, please comment		

Incidents

	YES	NO
Does the hospital have an incident policy and procedure in place which complies with the legislation and RQIA guidance?	YES	
Are all incidents reported, documented, fully investigated and have outcomes recorded in line the legislation, RQIA guidance and the hospital's policy and procedure?	YES	
No, please comment		

Infection Prevention and Control

	YES	NO
Does the hospital have an infection prevention and control policy and procedure in place?	YES	
Are appropriate arrangements in place to decontaminate equipment between patients?	YES	
Does the hospital use single use surgical instruments?	YES	
Does the hospital have appropriate service level agreements in place for the sterilisation of surgical equipment?	YES	
No, please comment		

Recruitment of staff

	YES	NO
Does the hospital have a recruitment and selection policy and procedure in place?	YES	
Is all information outlined in Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005 retained and available for inspection?	YES	
Have all staff had an enhanced AccessNI disclosure undertaken, prior to commencing employment?	YES	
No, please comment		

Staffing

	YES	NO
Is there appropriate numbers of suitably qualified, skilled and experienced staff on duty to meet the assessed needs of the patients and the operational requirements of the hospital?	YES	
No, please comment		

Mandatory Training

	YES	NO
Are arrangements in place for all new staff to participate in an induction programme relevant to their roles and responsibilities?	YES	
Are arrangements in place for staff to access continuing professional development opportunities in line with the requirements of their professional bodies?	YES	
Are training records available which confirm that the following mandatory training has been undertaken:		
	YES	**NO**
Moving and Handling – annually	YES	
Protection of vulnerable adults – every 3 years	YES	
Safeguarding children (where services are provided to children) – every 3 years	YES	
Infection prevention and control training – annually	YES	

Fire safety – annually	YES	
Basic adult life support - annually	YES	
Basic paediatric life support (where services are provided to children) - annually	YES	
If No, please comment		

Appraisal

	YES	NO
Does the hospital have an appraisal policy and procedure in place?	YES	
Are systems in place to provide recorded annual appraisals for staff?	YES	
No, please comment		

Medical Practitioners, Nurses, Social Workers & Allied Health Professionals

	YES	NO
Are systems in place to ensure medical, nursing staff, social workers and allied health professionals have a current registration with their relevant professional bodies?	YES	
Are policies and procedures in place to grant, review and withdraw practising privilege agreements for medical practitioners?	YES	
Are practising privileges agreements in place for all medical practitioners? (where applicable)	YES	
Are systems in place to ensure that medical practitioners have up to date professional indemnity insurance?	YES	
Are systems in place to ensure that medical practitioners have an annual appraisal undertaken with a trained medical appraiser?	YES	
Are arrangements in place to ensure medical practitioners have a responsible officer?	YES	
No, please comment		

Surgical Services

	YES	NO
Are there suitable arrangements in place to provide appropriate pre-operative, peri-operative and post-operative care for patients?	YES	
Is an holistic assessment of patients care needs, using validated tools, carried out?	YES	
Are patient centred care plans developed and implemented for each patient and reviewed as changes occur?	YES	
Are contemporaneous medical records retained for each individual patient?	YES	
Does the hospital have a theatre manual in place?	YES	
Is there a register of operations retained that contains all of the information outlined in the legislation?	YES	
Does the hospital use the World Health Organisation (WHO) surgical checklist for each operation undertaken?	YES	
Does the hospital have systems in place for surgical pause?	YES	
Does the hospital provide endoscopy services?	YES	
Are there suitable arrangements in place for the provision of endoscopy services in line with best practice guidance? (where applicable)	YES	
Are systems in place to provide discharge information to patient's general practitioners and others involved in the patient's ongoing care?	YES	
Are arrangements in place for the collection, labelling, storage, preservation, transport and administration of specimens?	YES	
No, please comment		

4.0 Declaration

To be signed by the registered provider or registered manager for the establishment.

I hereby confirm that the information provided above is, to the best of my knowledge, accurately completed.

Name	Signature	Designation	Date
FIONA PATRICIA CARMICHAEL	F Carmichael	Ward + Registered Manager	15th Sept 2014