Announced Care Inspection Report
16- 17 November 2016

North West Independent Hospital

Type of service: Independent Hospital – Surgical Services
Address: Church Hill House, Ballykelly, BT49 9HS
Tel no: 02877763090
Inspectors: Winnie Maguire and Stephen O'Connor
RQIA's Medical Physics Advisor: Dr Ian Gillan

1.0 Summary

An announced inspection of North West Independent Hospital took place on 16 November 2016 from 10.30 to17.30 and 17 November 2016 from 9.30 to 14.00.

Dr Ian Gillan, RQIA's Medical Physics Advisor accompanied the inspectors to review the laser safety arrangements for the laser service; the findings and report of Dr Gillan are appended to this report.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the independent hospital – surgical services was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Observations made, review of documentation and discussion with Ms Finola Carmichael, registered manager, Ms Shirley Baird, clinical governance officer and staff demonstrated that in general systems and processes were in place to ensure that care to patients was safe and avoids and prevents harm. Areas reviewed included staffing, recruitment and selection, surgical services, laser safety, safeguarding, resuscitation and management of medical emergencies, infection prevention control and decontamination, and the general environment. One requirement has been made in relation to AccessNI enhanced disclosure checks. Four recommendations were made. One in relation to an issue identified in regards to recruitment and selection, two in regards to the laser service and one in regards to the provision of evidence that the resident medical officer has advanced life support training for adults and paediatrics.

Is care effective?

Observations made, review of documentation and discussion with Ms Carmichael ,Ms Baird and staff demonstrated that systems and processes were in place to ensure that care provided in the establishment was effective. Areas reviewed included clinical records, the care pathway, patient information and decision making and discharge planning. No requirements or recommendations have been made.

Is care compassionate?

Observations made, review of documentation and discussion with Ms Carmichael, Ms Baird and staff demonstrated that arrangements are in place to promote patients' dignity, respect and involvement in decision making. Areas reviewed included dignity, respect and rights, informed consent, breaking bad news and patient consultation. No requirements or recommendations have been made.

Is the service well led?

Information gathered during the inspection evidenced that there was effective leadership and governance arrangements in place which creates a culture focused on the needs of patients in order to deliver safe, effective and compassionate care. Areas reviewed included organisational and staff working arrangements, the arrangements for policy and risk assessment reviews, the arrangements for dealing with complaints, incidents and alerts, insurance arrangements, the arrangements for managing practising privileges and the registered person's understanding of their role and responsibility in accordance with legislation.

A recommendation was made in relation to the renewal of practising privileges in line with the hospital's policy and procedure.

This inspection was underpinned by 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, Social Services and Public Safety (DHSSPS) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	5

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Carmichael, registered manager and Ms Baird, clinical governance officer as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 5 October 2015.

2.0 Service details

Registered organisation/registered person: North West Independent Hospital Mr Philip Stewart	**Registered manager:** Ms Finola Carmichael
Person in charge of the establishment at the time of inspection: Ms Finola Carmichael	**Date manager registered:** 06 April 2011
Categories of care: Acute hospitals (with overnight beds)AH Acute Hospital (Day Surgery) AH(DS) Prescribed Technologies, Endoscopy PT(E) Prescribed Technologies, Laser PT(L)	**Number of registered places:** 35 in patients 13 day case places.

Laser equipment

Manufacturer: LSO Medical
Model: Endotherme 1470
Serial Number: unknown (laser not on site on the day of inspection)
Laser Class: 4

Laser protection advisor (LPA) - Mr Philip Loan

Laser protection supervisor (LPS) - Mr Zola Mzimba

Medical support services - Mr Zola Mzimba

Clinical authorised user - Mr Zola Mzimba

Types of treatment provided - Endovenous closure using laser therapy

3.0 Methods/processes

Questionnaires were provided to patients and staff prior to the inspection by the hospital on behalf of the RQIA. Prior to inspection we analysed the following records: notification of reportable incidents, complaints declaration and returned completed patient and staff questionnaires.

During the inspection the inspectors met with Ms Finola Carmichael, registered manager, Ms Baird, clinical governance officer , a theatre manager, a deputy theatre manager, a theatre senior staff nurse, a sterile services manager, two ward staff nurses, an estates officer, three patients and two sets of relatives. A tour of the premises was also undertaken.

Records were examined during the inspection in relation to the following areas:

- staffing
- recruitment and selection
- surgical services
- laser safety
- safeguarding
- resuscitation and management of medical emergencies
- infection prevention and control and decontamination
- clinical record recording arrangements
- management of patients
- patient information and decision making
- practising privileges arrangements
- management and governance arrangements
- maintenance arrangements

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 19 January 2016

The most recent inspection of the establishment was an announced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 05 October 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 15 (1) (b) **Stated:** First time	The registered person must ensure systems are in place to enable full compliance with the DHSSPS guidance on reducing the risk of Hyponatraemia when administering intravenous fluids to children and young people.	**Met**
	Action taken as confirmed during the inspection: The hospital has carried out an audit on 13 June 2016 in relation to compliance with the DHSSPS guidance on reducing the risk of hyponatraemia when administering intravenous fluids to children and young people. The compliance rate was very high. Since the last inspection staff have also attended external courses on the prevention of hyponatraemia.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 32.1 **Stated:** First time	It is recommended that a Venous Thromboembolism (VTE) Risk Assessment in line with the The National Institute of Health and Care Excellence (NICE) Clinical Guideline 92 on Venous thromboembolism in adults admitted to hospital: reducing the risk (June 2015) and hospital policy is undertaken for all patients undergoing surgery.	**Met**
	Action taken as confirmed during the inspection: It was confirmed continuous audit is in place to drive compliance with the NICE clinical guidelines on the VTE risk assessment. A robust action plan has been devised which includes the involvement of the hospital's medical advisory committee on the matter.	

4.3 Is care safe?

Staffing

A review of duty rotas, discussion with staff and completed staff and patient questionnaires demonstrated that there was sufficient staff in various roles to fulfil the needs of the hospital and patients. There is a multi-professional team which includes consultant surgeons, consultant physicians, anaesthetists, nurses, radiographers and allied health professionals, with specialist skills and experience to provide a range of hospital services including surgical services. A resident medical officer is available on site to provide medical cover between the hours of 18.00 and 08.00.

Review of the duty rotas confirmed that there was adequate staff in place to meet the assessed needs of the patients accommodated at the time of inspection.

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

Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place. Staff confirmed they felt supported and involved in discussions about their personal development. If staff development plans are developed as a result of appraisals these are forwarded to the hospital director for actioning.

There were systems in place for recording and monitoring all aspects of staff ongoing professional development, including specialist qualifications and training.

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

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

There was a process in place to review the registration details of all health and social care professionals.

Four personnel files of medical practitioners were reviewed and evidenced the following:

- confirmation of identity
- current registration with the General Medical Council (GMC)
- appropriate professional indemnity insurance
- appropriate qualifications, skills and experience
- ongoing professional development and continuing medical education that meet the requirements of the Royal Colleges and GMC
- ongoing annual appraisal by a trained medical appraiser

The inspectors confirmed that each medical practitioner has an appointed responsible officer.

Recruitment and selection

It was confirmed that four staff have been recruited since the previous inspection. A review of the personnel files for these staff demonstrated that in the main all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained. A review of documentation evidenced gaps of employment in the employment history of three of the four staff members. No records were retained to confirm that the identified gaps in employment had been discussed with the identified staff members. A recommendation has been made to address this.

A review of documentation demonstrated that the AccessNI enhanced disclosure check in respect of one of the newly recruited staff members had been received some eight days after they commenced work. It was also observed that the information available in respect of AccessNI checks was the letter issued by the umbrella body that processed the checks. No record had been retained by the hospital to confirm when they had received the check, who reviewed the check and the outcome of the review. A requirement has been made to address this.

There was a recruitment policy and procedure available. The policy was comprehensive and reflected best practice guidance.

Surgical services

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

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

The scheduling of patients for surgical procedures is co-ordinated by the theatre manager, the surgeon and booking office staff. The theatre lists take into account the individual requirements of the patient, the type of procedure to be performed, availability of equipment, staffing levels required, associated risks and level of sedation used.

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

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

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

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

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

On discussion staff confirmed that the surgical checklist based on the World Health Organisation (WHO) model is used in the hospital. A minor amendment was suggested to the format of the surgical safety checklist to identify who has provided the information when completing the surgical safety checklist. Completion of the surgical checklists is audited as part of the hospitals comprehensive clinical governance systems. Review of the audits confirmed that a high compliance rate is achieved.

The following areas of theatre practice were discussed with the theatre manager and theatre staff:

- prevention of intra-operative hypothermia
- intra-operative fluid management including intra-cavity fluid management
- mass blood loss in theatre
- availability of emergency lines
- anaesthetist's role
- the cleaning of theatres including deep cleaning

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

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

A review of the surgical register of operations which is maintained for all surgical procedures undertaken in the hospital found that it contained all of the information required by legislation.

Laser Safety

It was confirmed that the hospital had changed the provision of the laser service since the last inspection, these changes included:

- the removal of the previous laser and the cessation of laser treatments in the theatre area
- the introduction of a new laser
- the introduction of a new laser treatment – endovenous closure
- the provision of the new laser treatment in a room within the day procedure unit
- a new authorised user who is a consultant vascular surgeon

The laser was not on site during the inspection nor was there any laser protective eyewear. It was confirmed that the laser had been brought to the hospital together with the laser protective eyewear by a laser engineer who oversaw the installation and operation of the laser whilst on the hospital site. Ms Carmichael confirmed the laser service had been delivered on a monthly to six weekly basis.

These significant changes to the laser service provision had not been notified to RQIA. A recommendation was made to submit a variation to registration in relation to the laser service as outlined above. However following inspection, Ms Carmichael confirmed the laser service would only be delivered in the theatre area, in line with the registered arrangements and the hospital no longer wished to submit a variation of registration. It was agreed to rescind the recommendation in relation to this matter.

A laser safety file was in place which contained some of the relevant information in relation to laser equipment.

There was written confirmation of the appointment and duties of a certified laser protection advisor (LPA) which is reviewed on an annual basis.

Up to date local rules were in place which have been developed by the LPA. The local rules contained some of the relevant information pertaining to the laser equipment being used.

It was agreed RQIA will conduct a further inspection to review the provision of laser services. It was emphasised that the laser equipment must be on site together with all laser safety measures including the protective eyewear in line with the local rules.

A recommendation was made to ensure the following are in place:

- a laser safety file with information relating to the laser in use
- medical treatment protocols
- a laser register

A further recommendation was made to ensure there is evidence of application training and core of knowledge training for the authorised user.

Safeguarding

Staff spoken with were aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified, including who the nominated safeguarding lead was.

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

Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. The policy included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The relevant contact details for onward referral to the local Health and Social Care Trust should a safeguarding issue arise were included.

Resuscitation and management of medical emergencies

A review of medical emergency arrangements evidenced that emergency medicines were provided in keeping with the British National Formulary (BNF), and that emergency equipment as recommended by the Resuscitation Council (UK) guidelines was retained. A robust system was in place to ensure that emergency medicines and equipment do not exceed their expiry date. There was an identified individual with responsibility for checking emergency medicines and equipment. The emergency trolley at ward level was reviewed.

A review of training records and discussion with staff confirmed that staff have undertaken adult and paediatric basic life support training and updates and some staff had undertaken immediate life support training and updates. There is always at least one staff member with advanced life support training on duty at all times. There was no written evidence the resident medical officer has undertaken advanced life support training for adults and children. A recommendation was made on the matter.

Discussion with staff in relation to the arrangements regarding patients with a "Do Not Resuscitate" (DNR) order in place confirmed that patients who would have a DNR order in place would not meet the normal admission criteria for elective surgery within the hospital.

Occasionally a patient with a DNR order in place may be admitted for other procedures and following discussion appropriate arrangements were in place to document and review the DNR order under these circumstances.

Discussion with staff demonstrated that they have a good understanding of the actions to be taken in the event of a medical emergency and the location of medical emergency medicines and equipment.

The policy on resuscitation reflected best practice guidance. Protocols were available for staff reference outlining the local procedure for dealing with the various medical emergencies.

Infection prevention control and decontamination procedures

There were clear lines of accountability for infection prevention and control (IPC). The establishment has a designated IPC lead nurse.

There was a range of information for patients and staff regarding hand washing techniques.

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

Staff have been provided with IPC training commensurate with their role.

Discussion with staff confirmed they had a good knowledge and understanding of IPC measures.

A range of IPC audits have been carried out including:

- environmental
- hand hygiene
- surgical site infection

The results of these audits were displayed on a dedicated IPC noticeboard located in a corridor in the in-patient area. The compliance rate was noted to be very high and an action plan was in place for areas of non-compliance.

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

The hospital was found to be clean, tidy and well maintained.

A review of infection prevention and control arrangements indicated that very good infection control practices are embedded in the hospital

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

Environment

The environment was maintained to a high standard of maintenance and décor.

Detailed cleaning schedules were in place for all areas which were signed on completion. A colour coded cleaning system was in place.

A review of documentation and discussion with an estates officer demonstrated that arrangements are in place for maintaining the environment to include the servicing and maintenance of equipment, the fire detection system and firefighting equipment, portable appliance testing (PAT) of electrical equipment and the inspection of fixed electrical wiring installations. Review of documentation and discussion with the estates officer evidenced that a range of routine checks are undertaken and recorded in respect of the nurse call system, firefighting equipment, and the fire detection system to include emergency lighting and emergency break glass points and legionella control measures.

Review of documentation evidenced that the most recent fire risk assessment was completed by an external organisation during November 2016. The estates officer has developed an action plan to address the recommendations made within the fire risk assessment. Assurances were provided that all recommendations made within the risk assessment will be addressed by the end of 2016.

Review of documentation demonstrated that the most recent legionella risk assessment was completed by an external organisation during November 2016. The estates officer has developed an action plan to address the recommendations made within the risk assessment. Assurances have been provided that all recommendations made within the risk assessment will be addressed by the end of 2016. As discussed legionella control measures are in place and records retained.

The estates officer maintains an equipment register and is in the process of further developing this to include a complete asset register for the hospital.

Patient and staff views

Thirteen patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm. Comments provided included the following:

- “Completely safe”
- “All of the above were very good”
- “Felt very safe under Mr xxxx care.”

Twenty staff submitted questionnaire responses. All indicated that they felt that patients are safe and protected from harm. Staff spoken with during the inspection concurred with this. No comments were included in submitted staff questionnaire responses.

Areas for improvement

AccessNI checks must be undertaken and received prior to any new staff commencing work in the hospital.

Identified gaps in employment should be discussed with staff and any explanations given recorded, if applicable.

Ensure the following are in place in relation to the provision of the laser service:

- a laser safety file with information relating to the laser in use
- medical treatment protocols
- a laser register

Ensure there is evidence of application training and core of knowledge training for the authorised user.

Provide written evidence that the resident medical officer has undertaken advanced life support training for adults and children.

Number of requirements	1	Number of recommendations	4

4.4 Is care effective?

Care pathway

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.

Four patient records reviewed 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
- 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

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:

- “Excellent care”
- “All staff are friendly and very efficient”
- “Unbelievable attention”
- “Extremely well informed, felt very prepared for my surgery”
- “Impressed by the standards of care.”

Records

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

Information was available for patients on how to access their health records, under the Data Protection Act 1998.

The hospital is registered with the Information Commissioner’s Office (ICO).

Discussion with staff confirmed they had a good knowledge of effective records management. The hospital has a range of policies and procedures in place for the management of records which includes the arrangements for the creation, use, retention, storage, transfer, disposal of and access to records.

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

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

Discharge planning

The hospital has a discharge policy and procedure in place.

There are well developed discharge planning arrangements in place that require full engagement with patients and/or their representatives.

A discharge summary and plan is completed prior to the patient leaving the hospital. A letter is provided to the patient's general practitioner to outline the care and treatment provided within the hospital.

There are robust systems in place to ensure that agreed discharge arrangements are recorded and co-ordinated with all services that are involved in the patient's ongoing care and treatment.

Patient and staff views

All patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them. Comments provided included the following:

- “The care was very effective and timely”
- “Yes.”

All submitted staff questionnaire responses indicated that they felt that patients get the right care, at the right time and with the best outcome for them. Staff spoken with during the inspection concurred with this. The following comment was provided:

- "Patients are given an opportunity to sign care plans- audit done of records."

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

Dignity, respect and rights

Discussion with management and staff regarding the consultation and treatment process confirmed that patient's modesty and dignity is respected at all times. In-patients and day patients are accommodated in single rooms with en-suite facilities. Outpatients are provided with modesty screens and curtains as appropriate.

It was confirmed through the above discussion and observation that patients are treated in accordance with the DHSSPS standards for Improving the Patient & Client Experience.

Patients meet with the medical practitioner undertaking the treatment and are fully involved in decisions regarding their treatment. Patients' wishes are respected and acknowledged by the hospital.

Discussion with patients, staff and review of four patient care records confirmed that patients are treated and cared for in accordance with legislative requirements for equality and rights. Patient care records were observed to be stored securely in the nurses' office.

Staff were observed treating patients and/or their relatives/representatives with compassion, dignity and respect. Discussion with patients confirmed this. Comments received from patients included:

- "Everyone was polite and courteous to me"
- "Very well informed"
- "Staff always had time to listen."

All patients and/or their representatives are asked for their comments in relation to the quality of treatment provided, information and care received.

Discussion with patients and relatives confirmed they have the opportunity to comment on the quality of care and treatment provided, including their interactions with staff who work within the hospital.

Review of patient care records and discussion with patients, relatives and staff confirmed that treatment and care is planned and developed with meaningful patient involvement; facilitated and provided in a flexible manner to meet the assessed needs of each individual patient.

A policy and procedure was in place in relation to confidentiality which included the arrangements for respecting patient's privacy, dignity and providing compassionate care and treatment.

Breaking bad news

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

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

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

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

Following a patient receiving bad news, future treatment options are discussed fully with the patient and documented within their individual care records.

With the patient's consent, information will be shared with the patient's general practitioner and/or other healthcare professionals involved in their ongoing treatment and care.

Patient consultation

The hospital obtains the views of patients and/or their representatives on a formal and informal basis as an integral part of the service they deliver. All patients are given a patient satisfaction survey to complete. Completed surveys are collated monthly and the generated report is reviewed by Ms Baird.

In-patients, day patients, parents and children are offered the opportunity to complete a satisfaction questionnaire within the hospital.

A review of a random selection of completed questionnaires found that patients, parents and children were highly satisfied with the quality of treatment, information and care received. Comments received on the feedback questionnaires included:

- "Thoroughly satisfied"
- "All ok"
- "Happy with all"
- "Completely satisfied"
- "Very pleasant stay"
- "Best of staff in every corner"
- "All staff I came into contact with were very polite and courteous"
- "Very professional in all aspects"
- "Have always had excellent treatment"
- "Felt content and secure during my stay can't ask for better than that."

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 hospital and on the hospital's website.

Discussion with Ms Baird confirmed that comments received from patients and/or their representatives are reviewed by senior management within the hospital and an action plan is developed and implemented to address any issues identified and used to improve the delivery of service.

It was confirmed that the hospital is currently developing their website to facilitate patient comments and ratings.

Patient and staff views

All patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care. Comments provided included the following:

- "At all times"
- "The care could not have been better"
- "All nursing and theatre staff were very supportive."

All submitted staff questionnaire responses indicated that they felt that patients are treated with dignity and respect and are involved in decision making affecting their care. Staff spoken with during the inspection concurred with this. The following comment was provided:

- "Detailed questionnaires are given out and results are published."

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.6 Is the service well led?

Management and governance arrangements

There was a clear organisational structure within the hospital and staff were able to describe their roles and responsibilities and were aware of who to speak to if they had a concern. Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. There was a nominated individual with overall responsibility for the day to day management of the hospital. The registered provider monitors the quality of services and undertakes a visit to the premises at least monthly. Reports of the unannounced monitoring visits were available for inspection.

Systems were in place to ensure that the quality of services provided by the hospital is evaluated on an annual basis and discussed with relevant stakeholders. The hospital has a robust clinical governance committee involving all areas of the hospital service which meets on a four monthly basis

A clinical governance strategy and a quality improvement plan for 2015/17 are in place. Ms Baird, clinical governance officer, co-ordinates, implements and monitors governance arrangements within the hospital.

Staff confirmed Ms Carmichael operates 'an open door policy' for staff.

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

Arrangements were in place to review risk assessments.

A copy of the complaints procedure was available in the hospital Staff demonstrated a good awareness of complaints management. A complaints questionnaire was forwarded by RQIA to the hospital for completion. The evidence provided in the returned questionnaire, review of documentation and discussion with staff evidenced that complaints have been managed in accordance with best practice.

It was confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals which included:

- accidents and incident
- hand hygiene
- infection prevention and control
- controlled drugs
- documentation

If required an action plan is developed and embedded into practice to address any shortfalls identified during the audit process.

A system was in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies as appropriate. A system was also in place to ensure that urgent communications, safety alerts and notices are reviewed and where appropriate, made available to key staff in a timely manner.

The hospital has arrangements in place to monitor the competency and performance of all staff and if appropriate refer individuals to the relevant professional regulatory bodies in accordance with guidance.

Ms Carmichael outlined the process for granting practising privileges and confirmed medical practitioners meet with the hospital director and the application must be approved by the medical advisor committee prior to privileges being granted.

Five medical practitioner's personnel files were reviewed and it was confirmed that there was a written agreement between each medical practitioner and the hospital setting out the terms and conditions of practising privileges which has been signed by both parties. It was noted that the agreements have not been reviewed on a two yearly basis as outlined in the hospital's practising privilege policy and procedure. A recommendation was made to ensure practising privileges agreements are formally reviewed at least every two years.

North West Independent Hospital has a policy and procedure in place which outlines the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges.

A whistleblowing/raising concerns policy was available. Discussion with staff confirmed that they were aware of who to contact if they had a concern.

Ms Carmichael demonstrated an understanding of her role and responsibility in accordance with legislation. Information requested by RQIA has been submitted within specified timeframes. It was confirmed that the statement of purpose and patient's guide are kept under review, revised and updated when necessary and available on request.

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

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

Patient and staff views

All patients who submitted questionnaire responses indicated that they felt that the service is well managed. Comments provided included the following:

- "Staff are excellent and provided great care to myself while I was in their excellent hospital"
- "All staff were lovely and very friendly"
- "The service is very well managed"
- "I was fully informed at all times of what was happening to me and for me."

All submitted staff questionnaire responses indicated that they felt that the service is well led. Staff spoken with during the inspection concurred with this. The following comment was provided:

- "Audits are published in the staff room. Managers are approachable."

Areas for improvement

Ensure practising privileges agreements are formally reviewed on at least on a two yearly basis.

Number of requirements	0	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Carmichael, registered manager and Ms Baird, clinical governance officer as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on 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.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The DHSSPS Minimum Care Standards for Independent Healthcare Establishments(July 2014). They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to Independent.Healthcare@rqia.org.uk for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 19 (2) Schedule 2, as amended **Stated:** First time **To be completed by:** 17 November 2016	The registered provider must ensure that AccessNI enhanced disclosure checks are undertaken and received prior to any new staff commencing work and all relevant information in respect of the checks is retained.
	Response by registered provider detailing the actions taken: As the Registered Provider we always ensure that Access NI enhanced disclosure is undertaken and received prior to any new member commencing work.The one staff member with conflict of date of commencement of contract and NI Access date had been recruited through the Agency. We have a checklist developed to ensure that all relevant information is checked and signed off.
Recommendations	
Recommendation 1 **Ref**: Standard 14.2 **Stated:** First time **To be completed by:** 17 November 2016	Identified gaps in employment should be discussed with staff and any explanations given recorded, if applicable.
	Response by registered provider detailing the actions taken: There has been a form developed to document details of any gaps in employment, explanation and discussions with staff member to ensure that the staff member is supported. The staff member identified had been recruited through the Agency
Recommendation 2 **Ref**: Standard 48.12 **Stated:** First time **To be completed by:** 17 December 2016	Ensure there is evidence of application training and core of knowledge training for the authorised user.
	Response by registered provider detailing the actions taken: Evidence is now available re application training and core of knowledge training for the authorised user for the laser service.
Recommendation 3 **Ref**: Standard 48 **Stated:** First time **To be completed by:** 17 December 2016	Ensure the following are in place in relation to the provision of the laser service: • a laser safety file with information relating to the laser in use • medical treatment protocols • a laser register • evidence of application training and core of knowledge training for the authorised user.
	Response by registered provider detailing the actions taken: A Laser Safety File has been completed with the relevant information included i.e. evidence of application training, evidence of core knowledge training, medical treament protocols. The laser register has been updated to include description of area where procedure performed, duration of procedure, name of Consultant printed

	and details of any incident during procedure.

Recommendation 4 **Ref**: Standard 31.7 **Stated:** First time **To be completed by:** 17 December 2016	Provide written evidence that the resident medical officer has undertaken advanced life support training for adults and children.
	Response by registered provider detailing the actions taken: All Resident Medical Officers have been contacted to provide evidence of training in resuscitation including defibrillation and intubation skills. All Paeditric Lists are covered by RMO with PILs.
Recommendation 5 **Ref**: Standard 11.5 **Stated:** First time **To be completed by:** 17 December 2016	Ensure practising privileges agreements are formally reviewed on at least a two yearly basis.
	Response by registered provider detailing the actions taken: Practising Priveliges Agreement will be formally reviewed on at least a 2yrly basis.

The Regulation and Quality Improvement Authority

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

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews