North West Independent Hospital
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Inspectors: Jo Browne
Winnie Maguire
Inspection ID: IN022122

Announced Inspection of North West Independent Hospital

5 October 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An announced care inspection took place on 5 October 2015 from 10.00 to 17.20. Overall on the day of inspection the standards inspected were found to be generally safe, effective and compassionate. Areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

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's (DHSPPS) Minimum Care Standards for Healthcare Establishments 2014, The National Institute of Health and Clinical Excellence (NICE) Clinical Guideline 92 on 'VTE – Reducing the Risk' (January 2010) and guidance issued by DHSSPS on reducing the risk of hyponatraemia when administering intravenous fluids to children aged between four weeks and 16 years.

1.1 Actions/ Enforcement Taken Following the Last Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last inspection.

1.2 Actions/ Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

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

The details of the QIP within this report were discussed with Mrs Liz Dallas, chief executive and Ms Finola Carmichael, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details.

Registered Organisation/ Registered Person: North West Independent Hospital Mr Philip Stewart	**Registered Manager:** Mrs Finola Carmichael
Person in Charge of the Establishment at the Time of Inspection: Mrs Finola Carmichael	**Date Registered:** 06 April 2011
Categories of Care: AH – Acute Hospital with overnight beds, AH(DS) – Acute Hospital Day Surgery 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	**Number of Registered Places:** Inpatient - 36 Day cases - 13

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards have been met:

Standard 4 - Dignity, Respect and Rights
Standard 5 - Patient and Client Partnerships
Standard 6 - Care Pathway
Standard 7 - Complaints
Standard 32 - Surgery

Other areas inspected: Reducing the risk of Hyponatraemia when administering intravenous fluids to children and young people, incidents, insurance arrangements and RQIA registration.

4. Methods/Process

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

Prior to the inspection the following records were analysed: pre-inspection information, notification of incidents and complaints return.

During the inspection the inspectors met with the chief executive, registered manager, clinical governance/infection prevention and control (IPC) lead, theatre manager, senior staff nurse and two patients.

The following records were examined during the inspection:

- Six patient care records
- Patient satisfaction questionnaires
- Summary report of patient satisfaction questionnaires
- Complaints records
- Policies and procedures
- Surgical checklists
- RQIA certificate of registration
- Surgical register of operations
- Theatre manual
- Service records for theatre equipment
- Incident/accident records
- Insurance documentation
- Training records
- Audits records
- Clinical Governance Strategy

5. The Inspection

5.1 Review of Requirements and Recommendations from Previous Inspection

The previous inspection of the hospital was an announced estates inspection on 30 October 2014. The completed QIP for this inspection was returned to RQIA on 09 January 2015. Follow up in relation to one issue from this QIP is still ongoing with the estates inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection Dated 15 October 2014

Previous Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref:** Standard 9.5 **Stated:** First time	The registered manager should ensure that minutes are retained of all meetings with the registered provider.	**Met**
	Action taken as confirmed during the inspection: A quality of service monitoring form is completed by the registered person on a monthly basis which includes all issues discussed with the senior management team. Review of the completed forms confirmed this recommendation has been fully addressed.	
Recommendation 2 **Ref:** Standard 16.3 **Stated:** First time	The registered manager should ensure that the absence of registered manager policy is updated to reflect the current management arrangements within the hospital.	**Met**
	Action taken as confirmed during the inspection: Review of the absence of the registered manager policy confirmed that it had been updated to reflect the current management arrangements within the hospital.	

Recommendation 3 **Ref:** Standard 32.1 **Stated:** First time	The registered manager should ensure that robust policies and procedures are developed for the management of intra-operative fluids.	**Met**
	Action taken as confirmed during the inspection: Review of the policies and procedures, along with discussion with staff, highlighted that some further development is needed in relation to the management of intra-operative fluids. The revised policy and procedure along with the fluid balance chart to be used in theatre was submitted to RQIA on 9 October 2015 via email.	

5.3 Standard 4 – Dignity, Respect and Rights

Is Care Safe?

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

Patient care records were observed to be stored securely.

Is Care Effective?

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. A copy of the document was available within the hospital as a reference for staff. Review of the North West Independent Hospital's Quality Improvement Plan 2015-2017 confirmed that patient experience is included within and central to the hospital's clinical governance strategy.

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 establishment.

Is Care Compassionate?

Discussion with two patients, staff and review of six patient care records confirmed that patients are treated and cared for in accordance with legislative requirements for equality and rights.

Staff were observed treating patients and/or their representatives with compassion, dignity and respect. Discussion with patients confirmed this.

Comments received included:
"Put me at ease."
"Very aware of my privacy."

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of Requirements	**0**	**Number Recommendations**:	**0**

5.4 Standard 5 – Patient and Client Partnership

Is Care Safe?

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

The information from the patient comments is collected in an anonymised format, summarised and used by the establishment to make improvements to services.

Is Care Effective?

North West Independent 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. The hospital has developed a comprehensive clinical governance strategy which includes patient experience, safe care, effective care and regulation compliance.

The establishment issued feedback questionnaires to patients and which were returned and completed. Review of 150 completed adult questionnaires from August 2015, 20 paediatric questionnaires and the summary reports from January 2015 to June 2015 found that patients were highly satisfied with the quality of treatment, information and care received.

Comments from adult patients attending the hospital included:
“All staff very helpful, attentive and good.”
“First class, best ever hospital visit.”
“Made me at ease and not frightened at all, so happy and have recommended to others to go here.”
“All staff treated me with exceptional care and kindness.”
“Would highly recommend this hospital to everyone.”
“I have been treated so well by the nurses, they are fantastic nurses who could not do enough to help.”

Comments from parents of children attending the hospital included:
“Just brilliant.”
“Staff are excellent, so good with children.”
“Hospital is very clean.”
“Lovely friendly atmosphere.”
“Kind and very caring and understanding.”

The information received from the patient feedback questionnaires is collated into summary reports which are made available to patients and other interested parties to read on the notice boards within the ward and outpatients.

Discussion with the clinical governance lead confirmed that comments received from patients and/or their representatives are reviewed by senior management on a monthly basis. A robust action plan is developed and implemented to address any issues identified.

Is Care Compassionate?

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

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

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of Requirements	**0**	**Number Recommendations**:	**0**

5.5 Standard 6 – Care Pathway

Is Care Safe?

Discussion with patients and staff confirmed that a range of clinical assessments are undertaken by the different members of the multidisciplinary 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.

Review of six patient care records found that they contained comprehensive information relating to pre-operative, intra-operative and post-operative care provided which clearly outlined the patient pathway and included the following:

- Patient personal information
- Range of 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/or their representatives and review of the care records confirmed that patients are involved in planning their care and treatment. The hospital has piloted arrangements to enable patients to sign their care plans for major surgery to confirm that care has been discussed with them. Discussion with staff confirmed that this will be rolled out across the care plans for all types of surgery undertaken.

Discussion with patients 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 were signed by the consultant surgeon and the patient.

Comments received from patients regarding the care received in the hospital included:
"Very well informed about procedure."
"Excellent staff."

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. Discussion with senior management confirmed that most children are treated as day surgery 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, with the consent of the patient.

Is Care Effective?

The establishment has arrangements and facilities in place to meet the assessed needs of each individual patient from admission through to discharge and review.

Appropriately trained and qualified health care professionals are available to contribute to the multidisciplinary review of the outcomes of the patient treatment and care provided by the hospital.

Is Care Compassionate?

Discussion with two patients confirmed that they 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.

The establishment has a wide range of information leaflets available regarding the various types of procedures available. The chief executive confirmed that any information can be provided in an alternative language or format if required and outlined the arrangements for the provision of an interpreter service.

Discussion with patients confirmed that they had received comprehensive information prior to their admission and from the multi-disciplinary team following their admission.

Review of the care records and discussion with patients confirmed that the treatment plan is agreed with the patient and the ongoing care needs are communicated effectively to the multi-disciplinary health care team.

Staff and patients confirmed that the results of investigations and treatment provided is explained to the patients and future treatment options are discussed and patients are involved in the decision making process.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of Requirements	**0**	**Number Recommendations**:	**0**

5.6 Standard 7 - Complaints

Is Care Safe?

Review of complaint records found that complaints are investigated and responded to within 28 working days (in line with regulations) or if this is not possible, complainants are kept informed of any delays and the reason for this.

Discussion with the registered manager and clinical governance lead confirmed that information from complaints is used to improve the quality of services.

Is Care Effective?

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers. However, if there is considered to be a breach of regulation as stated in The Independent Health Care Regulations (Northern Ireland) 2005, RQIA has a responsibility to review the issues through inspection.

A complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the hospital for completion. Review of the complaints records, discussion with staff and the evidence provided in the returned questionnaire indicated that complaints have been managed in accordance with best practice.

The registered manager demonstrated a good understanding of complaints management. Discussion with staff evidenced that they know how to receive and deal with complaints.

Review of the complaints register and complaints records evidenced that all complaints were well documented, fully investigated and had outcomes recorded in line with the complaints procedure and legislation. Complaints records were observed to be stored securely in line with data protection legislation.

A complaints audit is undertaken quarterly by the clinical governance lead. The audit information is used to identify trends and enhance services provided as part of the establishment's quality assurance arrangements. The information is also shared on a monthly basis with the responsible individual, Mr Stewart.

The complaints procedure is contained within a complaints leaflet and the Patient Guide; copies of which are available in the ward and outpatients for patients to read. Both patients who met with the inspectors had copies of the complaints procedure within their rooms and felt they would be able to raise any concerns with staff. However no concerns were raised at the time of inspection and both spoke very positively regarding the care and treatment they had received.

Is Care Compassionate?

A copy of the complaints procedure is provided to patients and to any person acting on their behalf. The procedure is available in a range of formats suited to the patient's age and level of understanding if required.

The complainant will be notified of the outcome and action taken by the clinic to address any concerns raised.

Discussion with staff demonstrated that the core values of privacy, dignity, respect and patient choice are understood. Complaints were found to be handled in a sensitive manner.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of Requirements	**0**	**Number Recommendations**:	**0**

5.7 Standard 32 - Surgery

Is Care Safe?

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 and 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, associated risks and level of sedation used.

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 met with the theatre manager and a senior staff nurse to discuss staffing levels. The theatres were found to have adequate levels of appropriately skilled and qualified staff to meet the individual needs of the patients undergoing surgery.

There is an identified senior member of nursing staff, with theatre experience, in charge of the operating theatre at all times. A permanent record is retained of the name of nurse in charge of each theatre. It was advised that the full name of the staff member is recorded in the allocation diary in line with the duty rota.

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

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 or to home for day patients. Staff confirmed that an anaesthetist approves each patient for discharge from recovery.

Equipment, installations and facilities are in place to provide the services outlined in the hospital's Statement of Purpose. There are systems in place to ensure that theatre equipment is maintained and decontaminated in line with the manufacturers' guidelines. A sample of maintenance contracts and servicing records were reviewed during the inspection.

Is Care Effective?

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.

On discussion staff confirmed that the surgical checklist based on the World Health Organisation (WHO) model is used within the hospital. 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 were discussed with the theatre manager and a member of the theatre team. Staff displayed a good understanding of the topics discussed. Following the previous inspection the hospital had implemented policies and procedures for the management of intra-operative fluids and was training staff accordingly. Review of the documentation and discussion with staff highlighted that further development of the procedures is required particularly in relation to the timescales for recording intra-operative fluid balance, identifying trigger factors for positive and negative fluid balances and the action to be taken if an issue is identified. A revised policy and procedure on the management of intra-operative fluids along with the fluid balance chart to be used in theatre was received by RQIA on 9 October 2015 which addressed the concerns identified during the inspection.

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) had been implemented by the hospital. Review of the care records showed that the assessment was completed for three patients undergoing cosmetic surgery on the day of inspection. However the risk assessment had not been completed for ophthalmic surgery patients. Following discussion with staff it was established that the VTE risk assessment would not normally be completed for ophthalmic surgery patients. Review of the hospital's VTE policy and procedure confirmed that all patients undergoing surgery should have this risk assessment completed.

Review of the surgical register of operations, which is maintained for all surgical procedures undertaken in the hospital, confirmed it contained all of the information required by legislation. The registers of all types of surgical implants were also reviewed and found to be compliant with best practice. The hospital reports all orthopaedic implants to the National Joint Register (NJR).

Is Care Compassionate?

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

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

The information is available in a range of formats suited to the patient's age and level of understanding if required.

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

Patients are provided with written post-operative instructions relevant to their individual procedure which may include information on:

- Pain relief
- Bleeding
- Care of the post-operative site
- The potential effects of anaesthesia
- Information on post-operative exercises and recovery information
- Arrangements for ongoing care and review
- Emergency contact information in the event of post-operative complications

Areas for Improvement

Ensure a VTE risk assessment is undertaken for all patients undergoing surgery in line with the NICE guidance and the hospital's policy and procedure.

Number of Requirements	**0**	**Number Recommendations**:	**1**

5.8 Additional Areas Examined

Reducing the risk of Hyponatraemia when administering intravenous fluids to children and young people

It was confirmed that the hospital had received and implemented the recent guidance issued by DHSSPS in January 2015 in relation to reducing the risk of Hyponatraemia when administering intravenous fluids to children and young people between the ages of 4 weeks and 16 years.

The National Patient Safety Agency (NPSA) Audit checklist completed in April 2015 and an action plan has been developed.

In line with the guidance the hospital have developed and implemented the following:

- Local intravenous fluid guidelines
- Arrangements for reporting hospital acquired Hyponatraemia to RQIA; the policy was amended during the inspection
- Arrangements for ongoing audit

The National Patient Safety Agency (NPSA) Audit checklist was completed in April 2015 and an action plan has been developed, however some issues identified by the checklist had not been progressed at the time of inspection. To ensure full implementation of the DHSSPS guidance the following should be developed and implemented:

- Competency framework for administration of intravenous fluids
- Training for all staff involved in prescribing, administering and monitoring intravenous fluids
- The regional paediatric fluid prescription and fluid balance chart

Training had been undertaken by nurses with paediatric life support training. However evidence was not available for other staff or medical practitioners.

Management of Incidents

The establishment has an incident policy and procedure in place which includes reporting arrangements to RQIA.

Review of incident management found that incidents were documented, fully investigated and had outcomes recorded.

Audits of incidents are undertaken quarterly as part of the hospital's clinical governance systems and learning outcomes are identified and disseminated throughout the organisation.

RQIA Registration and Insurance Arrangements

Review of documentation and discussion with staff confirmed that current insurance policies were in place. The certificates of RQIA registration and insurance were clearly displayed in the premises.

Areas for Improvement

Ensure full compliance with the DHSSPS guidance on reducing the risk of Hyponatraemia when administering intravenous fluids to children and young people.

Number of Requirements	**1**	**Number Recommendations**:	**0**

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Liz Dallas, chief executive and Ms Finola Carmichael, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 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.

6.1 Statutory Requirements

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

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Department of Health, Social Services and Public Safety's (DHSPPS) Minimum Care Standards for Independent Healthcare Establishments. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to independent.healthcare@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the establishment. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the establishment.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref:** Regulation 15 (1) (b) **Stated:** First time **To be Completed by:** 5 November 2015	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.
	Response by Registered Manager Detailing the Actions Taken: A system has been iniated to ensure full compliance with the DHSSPS guidance on reducing the risk of Hyponatraemia when administering intravenous fluids to children and young people. - Letter sent to Consultants/Consultant Anaesthetists who participate in c/o Paediatrics & Young People to forward necessary training documents. -Framework documenting skills obtained in Prescribing/ Administering IV fluids to children & Young people -Information Leaflet for all staff who partipate in c/o Paediatric & Young People. -Competency Assessment tool for all Nursing/Theatre staff
Recommendations	
Recommendation 1 **Ref:** Standard 32.1 **Stated:** First time **To be Completed by:** 5 November 2015	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.
	Response by Registered Manager Detailing the Actions Taken: Venous Thromboembolism Assessment is to be completed in line with the National Institute of Health and Care Excellence(NICE)Clinical Guideline 92 and NWIH policy to reflect these guidelines.

Registered Manager Completing QIP	S. L. Carmichael	**Date Completed**	12/11/2015
Registered Person Approving QIP		**Date Approved**	12/11/2015
RQIA Inspector Assessing Response		**Date Approved**	

Please ensure this document is completed in full and returned to independent.healthcare@rqia.org.uk from the authorised email address

RQIA Inspector Assessing Response	Jo Browne	**Date Approved**	01/12/15