Announced Care Inspection Report
24 and 25 July 2018

Kingsbridge Private Hospital

Type of Service: Independent Hospital – Surgical Services
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Membership of the Inspection Team

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

1.0 What we look for

RQIA has employed refreshed inspection methodology, which is also used in Health and Social Care (HSC) hospitals across Northern Ireland; we are extending this methodology to underpin inspections of independent hospitals and hospices during this year.

2.0 Profile of the Hospital

Kingsbridge Private Hospital provides a wide range of surgical services, a minor injuries service, outpatients and a private general practice (GP) service. Adult and paediatric services are provided. The hospital is registered to accommodate up to 16 in-patients and six day surgery patients.

The hospital has two theatres, a dedicated endoscopy suite, a small x-ray department and a range of consulting rooms. The in-patient accommodation comprises of single en-suite rooms which are situated over two floors. The day surgery unit is located on the first floor of the premises.

3.0 Service details

Organisation/Registered Provider: 3fivetwo Medical Ltd **Responsible Individual:** Mr Mark Regan	**Registered Manager:** Ms Sarah Marks
Person in charge at the time of inspection: Ms Sarah Marks	**Date manager registered:** 10 December 2013
Categories of care: Independent Hospital (IH) – Acute hospital (with overnight beds) AH Acute Hospital (Day Surgery) AH(DS) Prescribed Technologies, Endoscopy PT(E) Prescribed Technologies, Laser PT(L) Private Doctor PD	**Number of registered places:** 16 inpatient beds 6 day surgery beds

4.0 Inspection summary

An unannounced inspection was undertaken to Kingsbridge Private Hospital (KPH) over two days, commencing on Tuesday 24 July 2018 and concluding on Wednesday 25 July 2018.

RQIA employed a refreshed inspection methodology during this inspection, which has been used successfully in Health and Social Care (HSC) hospitals across Northern Ireland. This methodology will be used to underpin inspections of independent hospitals and hospices in the future.

We would like to thank Mr Regan, Ms Marks and all of KPH staff for being welcoming, open and transparent, and for providing the inspection team with information and documents they required in a timely manner.

The inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Independent Health Care Regulations (Northern Ireland) 2005, The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health (DOH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

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

No immediate concerns were identified in relation to patient safety, and the inspection team noted multiple areas of strength, particularly in relation to the delivery of front line care in the hospital.

We escalated the timing of this inspection due to concerns which were identified, by inspectors, following a review of incident notifications, which had been submitted to RQIA. The concerns centred on the timeliness of the notifications received and the provision of insufficient detail within the notification information.

A review of the clinical cases relating to notifications and discussion with staff, provided evidence that KPH has a system in place to identify and investigate matters requiring notification to RQIA. The inspection team was more assured that local processes and investigations are in place and are progressing. The current notification system is dependent on two members of staff, and the hospital was encouraged to reflect on their current approach to local investigations and share the expertise more widely, to build a sustainable process to reporting across the KPH system. This will ensure that the current system is not dependent on a small number of specific staff and is balanced between reviewing equipment, procedures and clinical practice.

Patients advised they were very happy with their care and positive interactions between staff and patients were observed. There was a very good choice of nutritious meals, the meal service was well coordinated and patients received their meals in a timely way and were assisted as needed.

Staffing levels and morale on the wards were good, with evidence of multidisciplinary team working and open communication between staff. Staff feedback was positive. They told us that they were happy, felt supported and well engaged, and that there were good productive working relationships throughout the hospital. Administration staff highlighted some challenges in relation to scheduling a high volume of admission requests.

A review of patients' nursing records/documentation demonstrated that they were very well completed, concise and clear, and flagged very few errors.

There was evidence of good medicines management with medicine kardexes being well completed. Controlled drugs were well managed and audited and there was evidence of good pain management.

Inspectors identified some issues with regard to the resuscitation trolley in Ward one/recovery area, particularly in relation to the expiration dates of drugs and equipment. Following the inspection, Ms Marks confirmed that these issues had been addressed.

Inspectors reported a positive picture in theatres with evidence of good practice. There was a strong sense of leadership of the clinical area and good engagement between theatre staff was observed.

Infection prevention and control information was displayed on notice boards throughout the hospital and the team observed very good staff practice in relation to hand hygiene and the use of personal protective equipment. With the exception of Endoscopes, all other equipment in use in KPH is decontaminated by the South Eastern Health and Social Care Trust at the Ulster Hospital site.

Following an inspection in 2016, KPH was approved to undertake in-house post-procedure endoscope decontamination. Staff refresher training was discussed with Ms Marks who agreed that the staff would receive updated training, and that an overall system to assure and evidence best practice in decontamination of endoscopes would be implemented. Discussion also took place regarding whether or not Health Estates at the Department of Health intended to undertake follow up visits regarding decontamination processes. RQIA will clarify if follow up visits are planned and will recommend that any further visits are carried out jointly with an RQIA estates inspector.

With respect to clinical and organisational governance, the inspection team reviewed relevant documentation and discussed KPH's governance arrangements and systems with a number of staff, including Ms Marks, Mr Regan, Ms Partridge (Governance Manager) and Dr Tharma (Medical Director). Ms Marks confirmed that the existing governance policies and procedures are due to be reviewed shortly.

Clarification was sought regarding the hospital's Clinical Governance Steering Group and Assurance Committee as the inspection team was unclear about who chairs this committee, and whether or not it is a stand-alone group or part of the Medical Advisory Committee (MAC). Ms Marks confirmed that the Clinical Governance Steering Group and Assurance Committee is separate from the MAC; it meets before the MAC and it includes some members of the MAC. Dr Geoghegan suggested that delineating and clearly describing this committee and its functions would be beneficial.

The role and function of the medical and clinical governance lead was not clear and there was some ambiguity with respect to who had overall responsibility for medical and clinical governance. The importance of delineating responsibilities clearly, especially in relation to split roles, to ensure it is clear who is responsible for clinical governance and the related roles/areas within the hospital, was discussed.

The inspection team reviewed documentation relating to the MAC and its function. One of the functions of the MAC is to review information collated in response to adverse clinical incidents and to advise the hospital on corrective action when/as necessary. The inspection team could not see evidence of robust discussions and challenges, or a proactive approach to implementation of learning from adverse clinical incidents or actions agreed in response to audit findings. In addition, the MAC was not meeting quarterly as outlined in The Minimum Standards for Independent Healthcare Establishments.

Areas of strength identified for all wards and clinical areas included:

- plans to implement the Sepsis Six bundle
- engagement with Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) with a view to introducing the Person, Assessment, Plan of Care and Evaluation (PACE) nursing documentation

- KPH nursing staff attendance at the Regional Infection Prevention and Control Group meetings; and
- facilitation of nursing students from both Queens University and the University of Ulster.

In summary the areas of focus included:

- clearly delineating responsibilities with respect to the role and function of the medical and clinical governance lead
- reviewing the role and function of the MAC to ensure it is proactively meeting the needs of the hospital and providing the necessary guidance and expertise in respect of clinical matters
- reviewing the current processes with respect to the management and notification of incidents
- ensuring the staff responsible for decontamination of endoscopes have completed refresher training; and
- ensuring the current processes for the decontamination of endoscopes is audited and assured.

Additional areas of focus included auditing and assuring the contents of the resuscitation trolleys; completion of staff appraisals; minutes of staff meetings being available to all staff; and reviewing the current system for the completion of the pre-operative medical questionnaire.

The Quality Improvement Plan (QIP) should be completed and detail the actions taken to address the areas for improvement identified. The registered persons should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

At the conclusion of the inspection, Ms Marks provided some feedback to the inspection team with respect to the refreshed inspection methodology and the benefits of having a list of required documentation at the commencement of the inspection. Dr Geoghegan thanked Ms Marks for this feedback and advised that the inspection team would address the issue identified.

The findings of this report will provide KPH with the necessary information to assist them to fulfil their responsibilities, and enhance practice and patients' experiences.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	6	4

Details of the QIP were discussed with Mr Mark Regan, responsible individual; Ms Sarah Marks, registered manager; and Ms Brenda Partridge, governance manager on day two of the inspection. The timescales for completion commence from the date of inspection. A written summary of the feedback session was emailed to Mr Regan following the inspection.

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

4.2 Action/enforcement taken following the most recent care inspection dated 8 May 2018

No further actions were required to be taken following the most recent inspection on 8 May 2018.

5.0 How we inspect

Prior to the inspection a range of information relevant to the establishment was reviewed. This included the following records:

- notifiable events prior to and since the previous care inspection
- the registration status of the establishment
- written and verbal communication received since the previous care inspection
- the previous care inspection report.

Questionnaires were provided to patients during the inspection by the staff at KPH on behalf of RQIA. Returned completed patient questionnaires were analysed during and following the inspection. We invited staff to complete an electronic questionnaire during the inspection. Returned completed staff questionnaires were analysed following the inspection.

Posters informing patients that an inspection was being conducted were displayed.

The inspection team met with and spoke with the following staff: Mr Regan; Ms Marks; Ms Partridge; medical staff; nursing staff; healthcare assistants; allied health professionals (AHPs); the estates and facilities manager; catering staff; cleaning staff; and administration staff. One of the medical directors was spoken with via teleconference.

Ward 1, Ward 2 and Theatres were inspected and the inspection team was provided with a tour of the hospital.

A sample of records was examined in relation to the areas inspected.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 8 May 2018

The most recent inspection of the establishment was an unannounced care inspection.

6.2 Review of areas for improvement from the last care inspection dated 8 May 2018

There were no areas for improvement made as a result of the last care inspection.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Staffing

Within KPH there is a multi-professional team which includes consultant surgeons; consultant physicians; consultant ophthalmologists; anaesthetists; nurses; radiographers; and allied health professionals. A resident medical officer (RMO) is available on site to provide medical cover at all times and to meet the assessed needs of the patients accommodated in the hospital.

Staffing levels and morale on the wards were good, with evidence of good multidisciplinary working and good communication between staff. Staff told us that they were happy, felt supported and well engaged, and that there were good working relationships throughout the hospital. Administration staff highlighted some challenges in relation to accommodating all admission requests.

There are sufficient staff in various roles to meet the needs of the hospital and of patients. Staff were attending to patients in a timely and caring manner.

Systems were in place for recording and monitoring all aspects of staff ongoing professional development, including specialist qualifications and training. There was a process in place to review the registration details of all health and social care professionals, and to review the professional indemnity status of all staff who require individual indemnity cover.

A system of formal supervision sessions for staff has not yet been established. This was discussed with Ms Marks who confirmed that a new supervision system for staff is in the process of being implemented.

Procedures were in place for appraising staff performance and some staff confirmed that appraisals had taken place. However, only a small number of appraisals had been carried out during 2017 and 2018. An area for improvement against the standards has been made.

The personnel file of one of the medical practitioners reviewed did not contain evidence of the most recently completed whole practice appraisal. Ms Marks advised that this issue was being followed up.

An identified member of nursing staff, with theatre experience, is in charge of the operating theatre at all times. A permanent record of the nurse in charge of each theatre is retained. When planned surgery is undertaken on children there is always a skilled paediatric nurse in both the theatre and the recovery area.

There was evidence of good engagement between theatre staff, and good collaboration between administration staff and theatre staff.

Ms Marks advised that the hospital has recently facilitated nursing students from Queens University and the University of Ulster.

Recruitment and selection

During RQIA's previous announced inspection to the hospital in 2017, we made comment regarding the recruitment and selection process and were provided with assurances that KPH complies with its recruitment and selection policy. A review of the recruitment and selection documentation confirmed that improvements have been made and sustained.

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

KPH also employs a number of private doctors. A review of two personnel files of private doctors provided evidence that all of the relevant recruitment information had been sought and retained. It was confirmed that each private doctor has an appointed responsible officer.

Theatre/surgical services

Inspectors reported a positive picture with areas of good practice. The theatre manager was very proactive and focused. Inspectors were impressed with her knowledge and strong sense of ownership of the clinical area.

The surgical checklist based on the World Health Organisation (WHO) proforma is used in the hospital, and completion of surgical checklists is audited as part of KPH clinical governance systems. Staff confirmed that the WHO checklist is under review and will be updated to include the flushing of intravenous (IV) lines. The updated version is due to be implemented during August 2018.

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

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

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

The anaesthetist was observed visiting two patients prior to their surgery and it was confirmed that they are present throughout the operation and remain on-site until the patient has recovered from the immediate effects of the anaesthetic. Staff and patients confirmed that the surgeon also meets with the patient prior to the operation to discuss the procedure and obtain informed consent.

There are good systems and processes in place to ensure patients are observed during surgery and recovery by staff trained in anaesthetics and resuscitation. Discharge criteria must be met before a patient is transferred from recovery to the ward area.

Surgical registers are maintained for all surgical procedures undertaken in the hospital, and the register reviewed had been appropriately completed and contained all of the relevant information.

The theatre manager always ensures there is a skilled paediatric nurse in the theatre and recovery areas when surgery is undertaken on children. KPH does not operate on children under the age of four.

Safeguarding

Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm.

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. All staff had received training in safeguarding children and adults.

Medicines management

The RQIA pharmacist reported evidence of good medicines management. Kardexes were well completed, including completion of patients' body mass index (BMI) and allergy status. Controlled drugs were well managed and audited.

Medicines were managed by staff who had been trained and deemed competent to do so. Medicines had been administered as prescribed and there was evidence of systems in place to audit and monitor medicines management.

Medicines records were well maintained and readily facilitated the audit process.

The admission and discharge process in relation to medicines was reviewed. It was advised that written confirmation of the patient's medicine regime should be obtained on admission, to facilitate healthcare professionals' information regarding any additional supplies of medicine required post discharge. It was also advised that the actual quantity of any medicine supplied should be clearly recorded on the discharge form. Inspectors reported that the discharge letter may indicate the prescribed duration of treatment of a medicine, but the actual amount of medication given to patients at the time of discharge is not recorded. The importance of recording the quantity of medicine dispensed was discussed.

Controlled drugs were stored and administered safely. The controlled drugs register was signed by two registered nurses following administration. Reconciliation checks were completed at shift changes; however, it was identified that the person in charge of the controlled drug key was not involved in the actual shift checks. This should be reviewed to ensure that the person holding the keys is aware of the controlled drugs held in stock during their shift.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Largely, satisfactory systems were in place to alert staff to the expiry dates of medicines; and for the management of medicines which required cold storage.

Inspectors reflected that KPH provides patients with a three day supply of medication on discharge. This could potentially be problematic to a patient discharged before the weekend, who may be unable to make a timely appointment with their GP to request a follow up prescription. Ms Marks acknowledged this challenge and also highlighted that from a patient safety perspective the hospital is unable to prescribe and dispense long term medication, in particular controlled drugs or co-codamol.

Ms Marks also highlighted that some patients may experience challenges in securing further prescriptions from primary care (their GP or out of hours centre) at short notice. Mr Regan, confirmed that this matter has been raised with the Health and Social Care Board (HSCB) and is currently under discussion.

Resuscitation and the management of medical emergencies

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

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

Action was required to address issues identified with the resuscitation trolley in Ward 1/recovery area. The information recorded on the emergency medicine box in relation to the contents and expiry dates was overwritten and was difficult to read. The resuscitation trolley checklist did not reflect the items retained in the trolley. Ms Marks confirmed that action to address these issues was taken on the day following the inspection. The importance of reviewing the current system for checking resuscitation trolleys was discussed. An area for improvement against the regulations has been made.

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

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

Infection prevention and control (IPC) and decontamination

The wards and theatres were found to be clean, tidy and well maintained. Infection prevention and control information was displayed on notice boards in the wards, and good staff practice was observed in relation to hand hygiene and the use of personal protective equipment. Staff had a good knowledge and understanding of IPC measures.

Some of the nursing staff attend the Regional Infection Prevention and Control Group meetings and subsequently share their knowledge with other staff in the hospital. Staff also confirmed that there are plans to implement the Sepsis Six bundle, which is good to note.

The arrangements for the decontamination of equipment and reusable medical devices were reviewed. The decontamination of reusable medical devices, with the exception of endoscopes, is carried out by the South Eastern Health and Social Care Trust at the Ulster Hospital site. Following a joint visit to KPH in 2016, by a health estates engineer (Department of Health) and an RQIA estates inspector, KPH was approved to undertake post-procedure endoscope decontamination.

Ms Marks advised that there is no endoscopy nurse in the hospital and that the nurse in charge of the surgical list oversees the endoscope decontamination process. It was confirmed that the nurse would not use a scope unless it had the correct decontamination tag on it.

The staff responsible for the decontamination of endoscopes are employed by an external cleaning company, contracted to provide domestic services in KPH. There was no evidence of up to date staff training with respect to the decontamination of endoscopes and in discussion with the theatre manager, the estates and facilities manager and the cleaning company manager it was advised that this function is not within their remit of responsibility. It was unclear whether or not the staff carrying out the decontamination of endoscopes have the appropriate skills, knowledge and training. Staff initially received training to carry out this function in 2016.

The importance of ensuring that there are appropriate systems in place to provide assurance that staff are adhering to best practice procedures in relation to the decontamination of endoscopes was discussed. Ms Marks agreed that the staff undertaking the decontamination of endoscopes would receive updated training and that an overall system to assure and evidence best practice would be implemented. Two areas for improvement against the regulations have been made.

Dr Geoghegan agreed to clarify whether or not Health Estates (Department of Health) intended to undertake follow up visits (post 2016) regarding decontamination processes.

Environmental safety

The wards and theatres were maintained to a good standard. KPH has its own estates department which undertakes risk assessments and is responsible for maintaining the environment.

Areas of good practice

There were examples of good practice found in relation to staffing; staff recruitment and selection; medicines management; surgical services; infection prevention and control arrangements; safeguarding arrangements; and the environment.

Areas for Improvement

The current system for auditing and assuring contents of resuscitation trolleys should be reviewed and refreshed to ensure the system is more robust.

Staff responsible for decontamination of endoscopes should have completed refresher training in keeping with best practice guidance.

KPH must implement a system to audit and assure decontamination procedures in respect of endoscopes, to ensure decontamination of scopes is in keeping with best practice guidance.

Operational arrangements should be in place to assure staff appraisals are undertaken annually and a record is maintained.

	Regulations	Standards
Areas for improvement	3	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

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. 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, to discuss the nature of the surgery, the risks, complications and expected outcomes before signing a consent form. The consent forms reviewed were signed by the consultant surgeon and the patient.

Patients, who require it, are invited to attend a pre-operative assessment to identify and manage any risks prior to surgery. Prior to admission, administration staff contact the patient, by telephone, and complete a pre-operative medical questionnaire. The outcome of this completed questionnaire determines whether or not the patient is required to attend for a pre-surgical medical assessment.

The current system places a significant amount of responsibility on administration staff. Having identified the potential for ambiguity in patients' understanding of the questions being asked during this telephone call, it was agreed that the system should be reviewed. Ms Marks confirmed that in relation to the management of pre-operative risks, the current processes are under review to ensure that they appropriately identify pre-operative risks, in order that they can be appropriately managed. This includes the need to obtain a GP referral letter and any pre-surgical information regarding the patient's medical history and medication. An area for improvement against the regulations has been made.

Inspectors noted that patients' nursing records/documentation were stored securely and were well completed, concise and clear. Very few errors in nursing documentation were noted. They contained comprehensive information relating to pre-operative, peri-operative and post-operative care, which clearly outlined the patient pathway. Assessments were comprehensive and up to date and the delivery of care and treatment was regularly recorded. Systems were 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.

During discussion with patients they confirmed that they were very happy and felt involved in both their care and planning for discharge.

Ms Marks advised that the hospital is currently engaging with the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) to review its nursing documentation and there are plans to introduce the Person, Assessment, Plan of Care and Evaluation (PACE) nursing documentation, which is currently in use across the HSC hospitals in Northern Ireland.

Nutrition and hydration

The meal service was well co-ordinated, with patients receiving their meals in a timely way and being assisted as needed.

Nursing staff are responsible for the co-ordination of mealtimes and the recording of food and fluid intake. Feedback from patients was positive in relation to the availability of food and fluids, menu choices and the quality of the food served.

Discussion with the catering manager and a review of a sample of menus evidenced that there was a good choice of nutritious meals offered that included specific meals for patients requiring specialised diets, and meal times were flexible and tailored according to the patient's wishes and needs.

Pain management

It was the view of the inspection team that patients' pain was well managed. Patients confirmed that when they experienced pain, staff responded in a compassionate and timely manner.

One patient, who had experienced a higher level of post-operative pain than expected, confirmed that following examination by the Resident Medical Officer (RMO), they had received additional pain relief in a timely manner. The patient remained in hospital until they were comfortable and assessed as fit for discharge.

Communication

There was evidence of good multidisciplinary working and good communication between staff and patients. Staff confirmed that staffing levels and morale were good and that they were aware of whom to contact if they have a concern, and agreed that they can raise concerns openly and honestly.

Staff meetings had been held on a monthly basis and the minutes were retained. Some staff however indicated they had not received the minutes of the most recent staff meetings. The importance of timely dissemination and sharing of learning from serious adverse incidents, early alerts and other events, which should be evidenced in these minutes, was discussed. An area for improvement against the standards has been made.

Nursing and care staff attend a handover meeting at the beginning of each shift. The importance of handover reports in ensuring effective communication was discussed, and staff confirmed that the shift handover provided information regarding each patient's condition and any changes noted. Consideration should be given to developing a standardised template for documenting nursing handovers and safety briefs, to evidence both the content of these handovers and the dissemination of safety messages, during the handover and throughout the wards.

Areas of good practice

There were examples of good practice found in relation to the delivery of care, pain management, the completion of nursing care records, meals and mealtimes and communication between patients and staff.

Areas for improvement

The current system for completion of pre-operative medical questionnaires should be reviewed, to ensure it is clear and understood by patients.

Operational arrangements should be in place to ensure that minutes of staff meetings are disseminated in a timely manner and that they also evidence dissemination/sharing of learning.

	Regulations	Standards
Areas for improvement	1	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Person centred care

There was evidence of person centred care in KPH. Patients advised they were very happy with their care and positive interactions between staff and patients were observed throughout the inspection. Staff were observed treating patients with compassion, dignity and respect and introducing themselves and explaining procedures to patients in a kind and caring manner.

There was evidence that care and treatment is planned and developed with meaningful patient involvement and is facilitated and provided in a flexible manner to meet the assessed needs of each individual patient.

A call bell system was in place and patients confirmed that it was easily accessible and staff responded and attended to their needs in a timely manner.

Some staff were not wearing badges with their name and profession/designation clearly stated. This could be confusing for patients, as staff wear similar uniforms. This was discussed and it was recommended that all staff have their name and profession/designation clearly visible for patients.

Breaking bad news

Good systems and processes are in place for breaking bad news**.** Staff confirmed that when bad news is given to a patient and/or their representatives this is given by professionals with experience in this area of communication. Following a patient receiving bad news, future treatment options are discussed and fully documented in their care records. With the patient's consent, information is shared with the patient's GP and/or other healthcare professionals involved in their ongoing treatment and care.

Patient Engagement

The hospital obtains the views of patients and/or their representatives as an integral part of the service they deliver. Patients are offered the opportunity to complete a satisfaction questionnaire. The information received from these questionnaires is collated into an annual summary report which is made available to patients and other interested parties to read.

Patient engagement with the inspection team was positive and several thank you cards directed to hospital staff were observed on display.

Areas of good practice

Examples of good practice were found in relation to ensuring the core values of privacy and dignity were upheld and providing the relevant information to allow patients to make informed choices.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Clinical and organisational governance

The inspection team reviewed documentation and discussed KPH's governance arrangements and systems with a number of staff, including Dr Tharma, Mr Regan, Ms Marks and Ms Partridge. Ms Marks advised the inspection team that the existing KPH governance policies and procedures are due to be reviewed shortly.

Clinical governance

The overarching governance policy for KPH outlines the role and responsibility of the governance manager; however, there is no outline of the role and function of the medical and clinical governance lead. Dr Tharma confirmed during discussions that he is the medical director with responsibility for medical and clinical governance. However, the inspection team was informed that Dr Songra also had a role in medical and clinical governance.

The inspection team was not clear regarding the remit and responsibility of each of these directors. Ms Marks advised that KPH knows the separate responsibilities that each director has, however she noted that this might not be externally understood. As KPH capacity and expertise expands, it will be important to move from what is assumed to what can be assured.

The importance of delineating responsibilities clearly, especially with split roles, to ensure there is no ambiguity with respect to who is responsible for clinical governance and the related roles/areas within the hospital, was discussed and an area for improvement against the standards was made. Having these responsibilities clearly defined will further support the responsible individual and the registered manager, should they have a query or matter arising in relation to clinical governance.

With respect to the hospital's governance and oversight arrangements, KPH has a Clinical Governance Steering Group and Assurance Committee. Having reviewed the arrangements, in relation to this committee, it was unclear who chaired this group and whether or not the committee functions as a standalone group or if it is part of the MAC. Ms Marks explained that the Committee is separate from the MAC; it meets before the MAC and it includes some members of the MAC. Delineating and clearly describing this committee and its functions would be beneficial and would support KPH with respect to clinical governance and oversight. An area for improvement against the standards has been made.

The planned review of the hospital's existing governance arrangements will be a good opportunity to revisit existing roles and responsibilities to ensure they are clearly outlined.

Dr Simpson advised that a good working example might be to assess the systems and structures required should KPH need at some stage to suspend the practising privileges of a consultant. This is quite often an immediate/short notice decision, and it is important to have the structures in place to discuss, take and record the relevant decision. Dr Geoghegan advised it is important to have the appropriate systems in place, and also to ensure systems record and evidence discussions, decisions and actions in this regard.

KPH was encouraged to think about a system which supports arrangements for immediate decisions, as well as discussions taken at quarterly MAC meetings.

Medical Advisory Committee (MAC)

The hospital has a policy and procedure in place which outlines the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges. The MAC has a key role with respect to practising privileges. Systems are in place to review practising privileges agreements every two years. It was confirmed that a written agreement between each medical practitioner and the establishment was in place, setting out the terms and conditions of practising privileges, including the scope of practice, which has been signed by both parties.

The inspection team reviewed documentation relating to the MAC and its function. A clear constitution and detail of what information is presented at meetings of the MAC has been developed, examples of which include governance reports, incidents, notifications and audits.

The Minimum Care Standards for Independent Healthcare Establishments (2014), Standard 30, outlines that one of the functions of the MAC is to review information collated in relation to adverse clinical incidents and advise the hospital or management on corrective action when necessary.

The importance of the balance between a committee which receives information and a committee which actively discusses information to agree actions, identifies people responsible for taking actions forward and also reviews progress at subsequent meetings, was discussed.

The inspection team was unable to evidence robust discussions, challenges and a proactive approach to implementation of learning arising from audits and incidents. An example of this, from the paperwork reviewed, related to presentation of the results of an audit of theatre paperwork to the MAC. The audit demonstrated some gaps in documentation. The inspection team could not find evidence of active discussion of the audit results or actions agreed in response to the audit findings. The minutes of MAC meetings are currently written in a narrative form and hence may not include all the relevant information with respect to the outline of discussions, actions agreed and persons responsible for taking forward. Ms Marks agreed that these could be changed to provide a more accurate reflection of discussions progressed with actions and responsibilities agreed.

Dr Simpson suggested ways in which the MAC could delegate information for discussion at the Clinical Governance Steering Group and Assurance Committee. The MAC could then request an update on those discussions and subsequent progress of the actions agreed/implemented.

The Minimum Care Standards for Independent Healthcare Establishments (2014), Standard 30, outlines that the MAC should meet quarterly as a minimum with arrangements for extraordinary meetings as necessary. The Independent Health Care Regulations (Northern Ireland) 2005 also outline that the registered person must ensure that there are arrangements for identifying, recording analysing and learning from adverse incidents.

Review of MAC documentation indicated that two of four meetings over the previous year did not occur. A key role of the MAC is to assist the hospital's senior management team to assure and evidence safe practice, as well as providing the expertise to discuss and if necessary challenge practice of individual medical practitioners. Ensuring that the MAC is meeting quarterly as a minimum was discussed.

A focus of this inspection was the governance and oversight arrangements with respect to the management of clinical adverse incidents. This included the role of the MAC in advising the hospital management on any necessary corrective action. The inspection team was unable to evidence the correlation between the management of a number of clinical adverse incidents and the role and function of the MAC. An example of this was when the main focus of an investigation was on the equipment used during the procedure. The importance of ensuring there is a balanced focus in evidencing that both the equipment and the clinical practice(s) are being reviewed in instances such as these was discussed.

Given the key role of the MAC within the hospital, with respect to the matters outlined, an area for improvement against the regulations has been made.

Having met with the medical Responsible Officer (RO) the inspection team highlighted the benefits of the RO involvement in instigating conversations about consultants' clinical practice, should this be required, and having an input when the MAC are reviewing practising privileges.

Notifications/incident management

RQIA escalated the timing of this inspection due to concerns which were identified by inspectors, following a review of incident notifications which had been submitted to RQIA. The concerns centred on the timeliness of the notifications received and the provision of insufficient detail within the notification information. The inspection team reviewed files of 19 notifications previously received by RQIA as part of the established notification system.

The inspection team examined information pertaining to 19 notifications, provided by KPH, following which the inspection team was more assured that local processes and investigations were in place and were being progressed.

No immediate concerns were identified in relation to patient safety and the inspection team noted multiple areas of strength, particularly in relation to the delivery of front line care in the hospital.

The inspection team noted that staff are identifying incidents and events if/when they occur. Through internal KPH systems, appropriate groups of staff are alerted to the incident or event. The governance manager, medical lead and hospital management then assess and consider further actions, as required.

A review of the clinical cases and discussion with staff, provided evidence that KPH has a system in place to identify and investigate matters requiring notification to RQIA. However, the current system is dependent on two members of staff, and as a result the hospital was encouraged to reflect on their current approach. Expertise needs to be shared wider to build a sustainable approach across the KPH system, to ensure that the system for undertaking investigations is not dependent on a small number of specific staff.

Incidents are notified by KPH to RQIA via the web portal. This system is primarily based on and operated by one person, Ms Marks, in her role as registered manager for KPH. As this system places a lot of responsibility and pressure on one person, it was suggested that it was preferable to have a system which may be overseen by one person, but is operated by more than one person in KPH.

The inspection team noted that initial information forwarded to RQIA via the web portal is sometimes insufficient in detail and may not provide the necessary assurances. Ms Marks advised that the information on the submitted notification is taken from the hospital's internal incident form and inserted into the RQIA notification system. Discussion took place with respect to the challenge faced by KPH in meeting the reporting deadline of 24 hours post incident, while ensuring there is enough information contained within the report. An outline of what should be shared as soon as possible after the incident or event was discussed at feedback and accepted.

A review of notifications prior to the inspection evidenced that three patients had experienced the same post-operative complication. However, review of information in respect of notifications during the inspection evidenced that in fact nine patients had experienced the same post-operative complication. We were concerned that the hospital had not identified that nine patients had experienced the same post-operative complication. Ms Marks clarified that three patients were identified from one theatre list, which triggered the notification. The additional six patients were sporadic incidents identified prior to that group of three patients. It was advised that the relevant notification should be amended to reflect this information. Ms Marks has agreed to follow this up.

KPH shared some difficulties it has encountered with the RQIA notification system via the web portal. Dr Geoghegan confirmed that we will undertake further work in relation to the areas highlighted.

A review of a local KPH investigation into an incident where a patient developed pre-surgical complications, showed that there had been an indication of increased cardiac risk for this patient. This should have been identified during pre-operative screening, pre-medication assessment and/or pre-operative anaesthetic assessment. The inspection team could not evidence that the local investigation, undertaken by KPH, had clearly outlined where the pre-operative system failed to identify the cardiac risk.

In another case, a patient had not brought their medication or referral letter from their GP to KPH prior to surgery. The local KPH investigation clearly identified system failures and also identified learning. It was good to note that in this case there was evidence of learning and recommendations arising from this investigation were being progressed.

Dr Geoghegan reflected on both cases and highlighted that these are good examples of how local investigations can identify system failures and important learning.

The learning from investigations and how this is implemented was also discussed. Ms Marks advised that when an investigation is completed, learning is discussed and recorded in the minutes of weekly senior managers' meetings. It was not fully clear how learning is then implemented across the wider staff groups. Focused attention on multidisciplinary engagement to ensure dissemination of learning to all staff was encouraged. Dr Simpson shared a number of ways in which learning could be disseminated to staff and highlighted the importance of ensuring there is dedicated time for reflective learning for staff.

Given the importance of ensuring incidents are identified, reported and investigated appropriately and that any learning arising from the investigations is shared, an area for improvement against the regulations has been made.

Areas for improvement

The issues outlined with respect to the role and function of the MAC should be addressed.

The issues outlined with respect to incident management and notifications should be addressed.

The responsibilities for clinical governance should be reviewed and clearly delineated to ensure there is no ambiguity with respect to who has overall responsibility for clinical governance, operational management and any other relevant roles within the hospital. All roles need to be clearly defined and specified.

The role and function of the Clinical Governance Steering Group and Assurance Committee should be clearly described and delineated from the role and function of the MAC.

	Regulations	Standards
Areas for improvement	2	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Mark Regan, responsible individual and Ms Sarah Marks, registered manager, as part of the inspection process. The timescales for implementation of recommended actions commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to enforcement action. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

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

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005, The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health (DOH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

7.2 Actions to be taken by the service

A QIP should be completed to detail actions taken to address areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal. Returned QIP's will be assessed by the relevant inspector.

Quality Improvement Plan

Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 15 (6) **Stated:** First time **To be completed by:** 26 July 2018	The registered person shall review and refresh the current system for auditing and assuring contents of resuscitation trolleys, to ensure the system is more robust. Particular attention should be paid to recording of expiry dates of emergency medications and that equipment checklists accurately reflect actual items stored on the resuscitation trolleys. Ref: 6.4
	Response by registered person detailing the actions taken: At the time of the inspection one resuscitation trolley had an expired item on it due to European resupply issues and there was one extra item on the trolley that was not on a checklist. These areas were fixed at the time of the inspection. In the interim since the inspection all resuscitation trolleys have been reviewed and reorganised in line with new regional guidance shared at ILS and ALS courses from Resuscitation Council registered officer. All staff (both nursing and medical) have been made aware of the changes and have had the opportunity to familiarise themselves with the new trolley lay out and confirm their understanding.
Area for improvement 2 **Ref:** Regulation 15 (5) **Stated:** First time **To be completed by:** 26 September 2018	The registered person shall implement a system to audit and assure decontamination procedures in respect of endoscopes, to ensure decontamination of scopes is in keeping with best practice guidance. Ref: 6.4
	Response by registered person detailing the actions taken: Validation audits on the AER (endoscope washer) are completed weekly (inhouse by the AP(D)) and then quarterly and annually by the Manufacturer and signed by the AE(D). Drying cabinet is validated 6 monthly, this is audited annually by AE(D) and checked 6 monthly by AP(D) RO Unit is serviced and validated 6 monthly. Ventilation is validated quarterly. Cleaning and facilities are quarterly annually. The decontamination slip from the AER is attached to each set of patients notes as the scope is used for traceability

Area for improvement 3 **Ref:** Regulation 18 (2) (a) **Stated:** First time **To be completed by:** 26 September 2018	The registered person shall ensure that staff responsible for decontamination of endoscopes have completed refresher training in keeping with best practice guidance. Ref: 6.4
	Response by registered person detailing the actions taken: A programme of referesher training in decontamination procedures and handling of endoscopes is in place. Refresher training will be provided on review of competencies on an annual basis as part of the personal development and professional appraisal process. Refresher training may be provided adhoc if deemed necessary following identification of training need. Update and refresher training is provided at the time of any change to process, equipment or technique as guided by manufacturer or clinical guidelines.
Area for improvement 4 **Ref:** Regulation 15 (1) (a) & (b) **Stated:** First time **To be completed by:** 26 October 2018	The registered person shall review the current system for completion of pre-operative medical questionnaires, to ensure it is clear and understood by patients. Ref: 6.5
	Response by registered person detailing the actions taken: The pre operative questionnaire has been reviewed and staff have had training.
Area for improvement 5 **Ref:** Regulation 17 **Stated:** First time **To be completed by:** 26 October 2018	The registered person shall address the following matters with respect to the Medical Advisory Committee (MAC): • Ensure the committee meets on a quarterly basis (as a minimum) and arrangements are in place for extraordinary meetings as necessary; • Ensure that the committee is reviewing information in respect of adverse clinical incidents and is advising the hospital's senior management team on corrective action when/as necessary; • Ensure the committee is assisting the senior management team to assure and evidence safe practice • Ensure the committee is providing the expertise to discuss and if necessary challenge practice of individual medical practitioners; and • Minutes of MAC meetings must accurately reflect discussions progressed, actions agreed and persons responsible for taking forward actions within agreed timescales. Ref: 6.7
	Response by registered person detailing the actions taken: The MAC met 4 times between Jan 2018 and Jan 2019. There are quarterly meetings scheduled for 2019. There are arrangments for

	extraordinary meetings and this has previously been invoked as required. The outcomes, trends and learning from incidents is a standard item on the MAC agenda and any changes to policies are reviewed, altered to reflect current best practice and ratified by the MAC The senior team proactively look at alerts, new guidelines and recommendations as they come into practice. MAC members are consulted on these to help us assure safe practice is embedded in their implementation. The MAC has a mixture of expertise (Anaesthetics, Orthopaedic, Medical, General to name a few) to ensure a broad spectrum of knowledge to discuss issues in general and if necessary challenge practice The minutes template for the MAC have been altered to clearly reflect and evidence discussions and actions.
Area for improvement 6 **Ref:** Regulation 28 **Stated:** First time **To be completed by:** 26 October 2018	The registered person shall address the following matters with respect to incident management: • Review the current system, which is currently dependent on two members of staff, to ensure the expertise is shared more widely, to build a sustainable approach across the KPH; • Review the current system of incident investigation and management to ensure it is balanced between reviewing equipment, procedures and clinical practice; and • Disseminate the learning, from incidents, across all staff groups. The registered person shall address the following matters with respect to notifications: • Ensure that RQIA is informed of all incidents, in a timely manner, in keeping with the guidance statutory notifications of incidents and deaths for registered providers and managers ; • Ensure that the information sent to RQIA is sufficient in detail; and • Amend the current system for reporting to RQIA, via web portal, from one which is overseen by one person, to one that can be operated by more than one person. Ref: 6.7
	Response by registered person detailing the actions taken: The higher clinical governance system includes the Governance Manager and a salaried Doctor however the Clinical Director and Consultant Members of the MAC have regular input as required.

	The latest inspection highlighted an investigation that was ongoing and was looking at equipment as the likely cause of the issue however the clinical practice of the Consultant was also being reviewed. It would always be the case that all potential areas of cause were fully explored. A shared Learning Board has been located outside the canteen to ensure we capture all staff in the dissemination of learning. It was noted at the time of the inspection that the need for an additional nurse to supplement the team reporting and replying to RQIA on incidents had already been idenified by the General Manager. This Nurse has been in place since September and has supplemented the team to allow it to change the way incidents and complaints are handled resulting in an improvement in process, timeliness and detail.
Action required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments (July 2014)	
Area for improvement 1 **Ref**: Standard 16.1 **Stated:** First time **To be completed by:** 26 November 2018	The registered person shall ensure that responsibilities for clinical governance are reviewed and clearly delineated to ensure there is no ambiguity with respect to who has overall responsibility for clinical governance, operational management and any other relevant roles within the hospital. All roles need to be clearly defined and specified. Ref: 6.7
	Response by registered person detailing the actions taken: The Clinical Governance Strategy has been reviewed to delineate roles more clearly.
Area for improvement 2 **Ref**: Standard 16.1 **Stated: First Time** **To be completed by:** 26 November 2018	The registered person shall ensure that the role and function of the Clinical Governance Steering Group and Assurance Committee is clearly described and delineated from the role and function of the Medical Advisory Committee. Ref: 6.7
	Response by registered person detailing the actions taken: These two meetings have been separated and going forward the monthly Hospital Governance and Quality Meeting will feed relevant issues directly into the MAC. Additionally areas of escalation will be taken directly to the Clinical Director and if necessary an extraordinary meeting of the MAC arranged.
Area for improvement 3 **Ref**: Standard 13.9 **Stated:** First time **To be completed by:** 26 November 2018	The registered person shall ensure that operational arrangements are in place to assure staff appraisals are undertaken annually and a record is maintained. Ref: 6.4
	Response by registered person detailing the actions taken: At the time of the inspection staff appraisals for the year were underway (there will be some staff outwith the schedule as they are

	either new employees or have been on Maternity leave etc) and have now been completed. A record has been maintained.
Area for improvement 4 **Ref**: Standard 12.7 **Stated:** First time **To be completed by:** 26 October 2018	The registered person shall ensure that operational arrangements are in place to ensure that minutes of staff meetings are disseminated in a timely manner and that they also evidence dissemination/sharing of learning. Ref: 6.5
	Response by registered person detailing the actions taken: Whilst meeting minutes for individual department meetings are not emailed to individual staff, the meeting minutes are available to all staff in folders in the each department office and include shared learning which is discussed at meetings. However learning will have already been addressed with the relevant staff as appropriate via quality meetings, one to one meetings and group meetings where needed. There is a staff learning notice board that all staff across the hospital site have access and this is updated regularly by quality staff.

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

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