The Regulation and Quality Improvement Authority

Inspection Report

6 March 2023

Kingsbridge Private Hospital

Type of service: Independent Hospital
Address: 811-815 Lisburn Road, Belfast
Telephone number: 028 9066 7878

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Kingsbridge Healthcare Group Limited **Responsible Individual(s):** Mr Mark Regan	**Registered Manager:** Ms Kelly Macartney **Date registered:** 13 September 2022
Person in charge at the time of inspection: Ms Kelly Macartney	**Number of registered places:** 24 overnight/in patient beds (including two Intensive Care Unit beds) Five-day surgery beds
Categories of care: Independent Hospital (IH) Acute Hospital (with overnight beds) AH Acute Hospital (Day Surgery) AH(DS) Private Doctor PD Prescribed Technologies (PT) Endoscopy PT(E) Laser PT(L)	
Brief description of the accommodation/how the service operates: Kingsbridge Private Hospital in Belfast provides a wide range of surgical, medical and outpatient services for both adults and children. The hospital is registered to accommodate up to 24 patients as in-patients and five-day surgery beds. The hospital has three theatres, one of which is a fully functioning laminar flow theatre, along with recovery units; an x-ray department and a range of consulting rooms. The in-patient and day surgery accommodation comprises single en-suite rooms which are situated over two floors. The hospital is the first independent sector provider in Northern Ireland to register a critical care service providing intensive care unit accommodation for post-cardiac surgery patients 18 years and over, as specified on their registration condition, for aortic valve replacement; coronary artery bypass graft; mitral valve replacement; atrial myxoma and adult atrial septal defect. An application to update the registration of the critical care unit to include other surgical services that may require high dependency or post anaesthetic care was approved by RQIA in December 2022.	

<u>Laser Equipment</u> (located in Day Procedure Unit)

Manufacturer: Lumenis

Model: Aura PT

Class of Laser: Class 3B

Wave Length: Nd: YAG 1064nm

Serial No: YA44-0165

Laser Protection Adviser: Ms Anna Bass, Lasermet

2.0 Inspection summary

An unannounced inspection took place in Kingsbridge Private Hospital (KPH), Belfast on 6 March 2023 and concluded on 28 April 2023 with feedback to the Registered Manager (RM), Ms Kelly Macartney.

The hospital was inspected by a team comprised of care inspectors, medical practitioners and by an estates inspector who provided support remotely. An inspection of laser services was carried out by the Laser Protection Advisor (LPA) for RQIA and a laser report is appended to the end of this inspection.

This inspection focused on eight key themes including governance and leadership; patient care records; estates; surgical services/theatres; environment and infection prevention and control (IPC); safeguarding; staffing and laser service. The inspection also sought to assess progress with any areas for improvement (AFI) identified within the quality improvement plan (QIP) from the last inspection to KPH on 15 February 2022.

In addition to this, two key lines of enquiry (KLOE) were followed up; one relating to an increased reporting of notifications to RQIA from the hospital about post-operative gynaecology complications; and the second KLOE was with regards to a whistleblowing complaint about the governance arrangements for agency cleaning staff working in the hospital.

This was a very positive inspection highlighting good management and governance arrangements in place to ensure the overall quality and safety of the services provided. There are clear organisational structures in place and all staff are aware of their roles, responsibility and accountability within the overall structure.

Staff spoken with provided positive feedback on working in the hospital and of the support they receive from management. We did not receive any electronic feedback from staff.

Patients engaged with during the inspection were satisfied with the care they received.

A number of practical issues were identified and actioned during/following the onsite inspection.

There are no new AFI's identified as a result of this inspection.

3.0 How we inspect

RQIA's inspections form part of the ongoing assessment of the quality of services. The reports reflect how they were performing at the time of the inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during the inspections.

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

- the registration status of the establishment;
- written and verbal communication received since the previous inspection;
- previous inspection reports;
- QIPs returned following the previous inspections;

- notifications;
- information on concerns;
- information on complaints; and
- other relevant intelligence received by RQIA.

Inspectors assessed staff practices and examined records in relation to each of the areas inspected and met with the RM, members of the multidisciplinary team (MDT) and the senior management and governance team.

Experiences and views were gathered from staff and patients.

AFI's identified at the last care inspection were reviewed, and assessment of compliance recorded as met, partially met, or not met.

4.0 What people told us about the service

Posters informing patients, staff and visitors of the inspection were displayed whilst the inspection was in progress. The feedback from patients during the inspection was positive, indicating that they were happy with the care they had received, describing staff as helpful, kind and very polite. Communication was good and patients reported that they were fully informed of their clinical condition, planned care and rationale for any interventions. Postal questionnaires were distributed to patients and visitors; no responses have been received.

Several interviews with medical, nursing, allied health professional (AHP) and cleaning staff were conducted. These interviews included staff from three wards, theatres, outpatients and the recovery ward. Staff provided positive feedback asserting that they felt well supported by management, had good lines of communication and that morale was good. Staff were invited to complete an electronic questionnaire during the inspection. No electronic questionnaires were received by RQIA.

Interactions between patients and staff were observed throughout the hospital and this clearly evidenced patients were treated with compassion, dignity and respect. Consultation rooms and individual patient bedrooms were available in the hospital that facilitated patients to meet privately with medical practitioners whilst maintaining privacy and confidentiality.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or

The previous inspection to Kingsbridge Private Hospital was undertaken on 15 February 2022 by care inspectors; three AFI's were identified. These AFIs have been assessed as met.

Areas for improvement from the last inspection on 15 February 2022		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 18 **Stated:** First time	The Registered Person shall ensure that each person employed in or for the purposes of the establishment: - • Receives up to date mandatory training and other appropriate training.	**Met**
	This area for improvement has been assessed as met, further detail provided in section 5.2.7.	
Action required to ensure compliance with the Department of Health (DoH) Minimum Care Standards for Independent Healthcare Establishments (July 2014)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 8.2 **Stated:** First time	The Registered Person shall ensure that records are maintained for every patient and client in accordance with legislative requirements and best practice guidelines: - • The policy and procedure for record keeping in relation to patient treatment and care comply with guidelines and standards from statutory bodies.	**Met**
	This area for improvement has been assessed as met, further detail provided in section 5.2.2.	
Area for improvement 2 **Ref:** Standard 17 **Stated:** First time	The Registered Person shall ensure that all risks in connection with the establishment, treatment and services are identified, assessed and managed. This includes: - • where decisions to treat patients transferred from the cardiac surgical ICU to the ward are reached outside of planned arrangements there must be documented evidence of robust risk	**Met**

	assessments, inclusive of agreement with the ward manager.	
	This area for improvement has been assessed as met, further detail provided in section **5.2.2.**	

5.2 Inspection findings

5.2.1 Governance and Leadership

Clinical and organisational governance was reviewed. Appropriate governance systems were in place, including assurance and auditing systems to ensure the overall quality and safety of the services provided at the hospital. There was a clear organisational structure and staff were able to describe their roles and responsibilities and knew how to escalate concerns.

An examination of evidence confirmed a range of meetings in place including weekly management meetings, weekly intensive care unit (ICU) meetings, monthly local governance and quality meetings; and quarterly group governance and quality meetings across the Kingsbridge Healthcare Group. Clinical governance is overseen by the Medical Advisory Committee (MAC) which meets every quarter, and has arrangements in place for extraordinary meetings where necessary. Minutes of meetings were reviewed which confirmed that all relevant agenda items are covered at these meetings in line with the minimum standards.

Established morbidity and mortality (M&M) meetings also take place monthly, chaired by different clinical teams and focussing on speciality driven topics. Minutes of a recent M&M meeting relating to an increase in post-operative gynaecology complications were reviewed as part of the KLOE for the inspection. It was noted the minutes included detail on all aspects of the investigative process including any issues relating to staffing, equipment, environment and also included discussion around the complication rates for gynaecological procedures. Discussion with medical staff confirmed that investigations had taken place which included review of patient pathways, with no apparent themes arising. It was agreed that all appropriate actions had been taken to investigate each case and that the gynaecology surgical complication rates were not outside the expected limits.

There were systems in place to promote effective communication with all staff. There was evidence of daily staff briefs, regular staff meetings and information disseminated to staff directly from managers and by the use of learning boards. All staff reported how they receive feedback and learning via staff meetings, emails, minutes, group Whatsapp, directly from managers and via the learning board. Staff conveyed that they were happy to attend staff meetings online during their days off and that they receive time in lieu for attending.

A number of information technology (IT) systems which were in their infancy during the unannounced inspection to the hospital in February 2022 have been revised and further strengthened, these included “Doctract” to record patient records; and “Learnpool” to provide robust oversight of mandatory training for staff. Work to improve these IT systems is ongoing, which will further enhance the governance and oversight of documentation management and the staff training database.

Records held for service users and also records relating to the employment of staff were analysed and found to have good compliance with data protection policies. Records were securely maintained, accurately completed and detailed.

Risk management procedures were reviewed which provided assurance that risks identified within the hospital, treatment and services provided are identified, assessed and managed appropriately.

Robust systems were in place to monitor and mitigate risks relating to health, safety and welfare of service users and others. There were effective arrangements in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies as appropriate. A system was also in place to ensure that urgent communications, safety alerts and notices are reviewed and where appropriate, made available to key staff in a timely manner. Systems were in place for staff to review alerts and confirm they have read them.

A range of policies and procedures were accessible through the established IT system and evidenced. The IT system issues an alert when a policy is nearing its review date, enabling the policy author/group to review the policy and update in a timely manner. Policies and procedures examined were in date with a planned review date recorded and they were retained in a way that is easily accessible to all staff. This was confirmed with staff who were able to access a range of policies on request.

The complaints procedure and whistleblowing policy were available and staff were knowledgeable in what actions they should take to manage a complaint. Examination of the complaints register confirmed that information recorded for complaints included nature/type of complaint, department involved, clinical speciality involved, risk rating, outcome and complainant satisfaction. There was evidence of responding to complaints within appropriate timescales, and changes, including shared learning, implemented from complaints analysis.

A systematic programme of clinical internal and external auditing was in place to monitor the quality of services, with evidence of actions taken to promote service improvement. A range of audits were carried out and these were evidenced, with generally a high level of compliance noted, examples being, hand hygiene, mattress and environmental audits and some audits in relation to the governance oversight of agency staff, including cleaning staff. In addition to the internal monitoring at KPH, the external IPC advisor provides an additional mechanism of validation to the audit process.

Governance arrangements relating to recruitment procedures and mandatory training for agency cleaning staff working in the hospital were reviewed. It was noted that assurance mechanisms could be further strengthened to include confirmation that staff supplied by an agency have been recruited and checked in accordance with the recruitment procedures used by the hospital. The RM has reviewed the systems in place and provided assurance of a monthly audit programme being implemented to review agency staff employment and training records, additional to this would be to ensure robust SMART (specific, measurable, agreed, realistic, time bound) action plans are implemented when required.

Within independent healthcare establishments there is a responsibility on the management and medical assurance team to ensure the medical staff working there have the necessary and up to date skills and experience to practice. There are a number of assurances doctors must provide to the MAC before the doctor is granted practicing privileges. A policy and procedure is in place, which outlines the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges. There are systems to review practising privileges agreements every two years. The inspection team found that hospital management maintained a robust oversight of arrangements relating to practising privileges.

The Minimum Care Standards for Independent Healthcare Establishments (2014) states that doctors with practising privileges are required to provide evidence of their annual appraisal in line with General Medical Council (GMC) requirements. Governance arrangements to ensure annual medical appraisals were taking place and sufficiently comprehensive were reviewed. A number of

medical staff and surgical assistant personnel files were examined and overall relevant documentation was present in relation to professional indemnity and staff appraisals.
It was noted for two personnel files, whilst there was email evidence of professional indemnity renewal, the renewal certificate was missing. This was discussed with the RM during the inspection who provided evidence to confirm that all records are now in place.

Review of a random sample of recruitment files for nursing staff employed by the hospital, found all relevant documentation to be present with professional bodies registration at time of job application recorded. Whilst staff advised that registration with professional bodies is regularly checked during staff annual appraisals, there was no evidence to confirm this. Written assurance was received following the onsite inspection confirming that registration checks with professional bodies occurs during staff appraisals and it was suggested to add this action to appraisal documentation for validation.

Group supervision arrangements are in place and in addition staff confirmed opportunities to have one to one meetings with their manager if required.

The service has contributed to the Private Healthcare Information Network (PHIN) for a number of years, in an effort to benchmark the safety and quality of their services against similar services across the UK. Currently PHIN are unable to display this information on their website due to compatibility issues. The Responsible Individual confirmed that PHIN are endeavouring to resolve this issue.

Service users are encouraged to submit feedback on their treatment and care via an online healthcare review platform called “Doctify” which is described as giving patients more visibility of their healthcare options and confidence in booking appointments with specialists. All feedback is independently verified prior to publication on the website. The hospital currently has a rating of 4.78/5 and over 1900 reviews. There was evidence of this feedback being shared with staff aiming to continually evaluate and drive service improvement.

Staff spoken with said that they felt supported, respected and valued. Senior management described a culture of openness and transparency within the organisation. Theatre staff reported they were happy in their roles and confirmed that they felt well supported by the RM and the medical director.

Staff said they would feel comfortable raising any concerns, however, on occasion it was difficult to find a quiet space for staff to have confidential conversations. Discussion with the RM confirmed they were aware of this issue and that access to private areas will improve with the imminent opening of the new hospital extension.

There was a focus on staff health and wellbeing, with initiatives such as the step challenge which took place in February and became competitive as staff across Kingsbridge Healthcare Group competed for the highest number of steps walked; and the current focus for the month on healthy breakfasts.

The RQIA registration certificate and insurance certificate were displayed and up to date, and registration with Information Commissioner’s Office (ICO) certificate was also displayed.

5.2.2 Patient care records (Medical and Nursing)

A review of a sample of patient records confirmed that they included a contemporaneous note of each patient’s medical history, medicine regime, all treatment provided, and notes prepared by other health care professionals involved in their care. Patient care records were held in a secure environment. Computerised records were accessed using individual usernames and passwords.

An AFI was made previously as a result of the unplanned return of a cardiac patient to ICU and subsequent discharge back to the ward, where there was no documented evidence of a robust

risk assessment in place, which included agreement with the ward manager. No other patients have returned to ICU post transfer to the ward. A review of evidence confirmed that all patients are discussed at multidisciplinary ICU meetings and in conjunction with staff.
ICU trained nursing staff continue to be rostered on the ward to support ward staff when post cardiac surgery patients are transferred; and the training and competency programme for ward staff to care for post cardiac surgery patients is continuing until all staff are successfully trained. This AFI was assessed as met.

Nursing care records were found to be patient centred and care plans evidenced that patient needs were reviewed and met. Care records provided clear evidence of the care planned, the decisions made and the care delivered. The surgical pathway for cardiac patients evidenced a clear and chronological flow throughout the patient's journey in the hospital. The notes were easily navigated and clearly identified where one staff member finished their entry and where the next staff member would continue. An audit was completed on the patient notes to review legibility of hand written notes, signatory completion and chronology of entries. The results were discussed at the senior governance meeting and findings shared with relevant staff.

A review of patient assessments confirmed that National Early Warning Score (NEWS) charts were well completed and scores actioned if necessary. There were good patient pain management records and this was identified by staff as a key priority post-surgery. Nursing staff demonstrated a good knowledge of assessment and ongoing review of pain management. Staff described excellent links with the MDT to optimally manage this area of care for patients.

Some issues were identified for follow up - two patient records did not have risk assessments for venous thromboembolism (VTE) recorded, staff at ward level confirmed that VTE risk assessments should have been completed for these patients; and review of patient notes highlighted that the signature list at the front of the patient notes was not always fully completed to include professional registration number. This was discussed with the RM who provided assurance of immediate actions to be taken and plans in place to monitor/oversee.

5.2.3 Safeguarding

Arrangements for safeguarding of children and adults were reviewed. Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. Policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child.

Staff reported they have never had to raise a safeguarding concern in KPH but they would feel very confident to do so. They were aware of types and indicators of potential abuse in both adults and children and the actions to be taken should a safeguarding issue be identified, including who the nominated safeguarding champion in the hospital was. It was established that the safeguarding champion/s had recently changed and the RM agreed to update all relevant contact safeguarding personnel information displayed for staff.

An aide memoire was available on the ward as well as on the staff information boards outside the canteen for making safeguarding referrals. Staff were knowledgeable in the process to making safeguarding referrals.

The staff training matrix was evidenced and staff confirmed that they had received training in safeguarding children and adults at a level appropriate to their role.

A whistleblowing/raising concerns policy was available which provided guidance to help staff make a protected disclosure should they need or wish to. Staff confirmed that they knew who to contact should they have concerns or needed to discuss a whistleblowing matter.

5.2.4 Estates

Documentation in relation to the maintenance of the premises, including mechanical and electrical services, was reviewed remotely. The KPH management team were provided with a checklist of documents to submit for estates inspector review. The checklist contained maintenance/test verification certificates related to building engineering services. All requested documents were submitted, and found to be compliant with the relevant codes of practice and standards.

Maintenance works are completed by specialist sub-contractors and directly employed engineers/competent persons.

The Authorising Engineer (AE) Audit report for the engineering services was completed following AE site visit on 24 February 2023.

The AE report reviewed the following engineering services:

- HTM 02-01 : Medical Gas Pipeline Systems;
- HTM 03-01: Specialist ventilation for healthcare premises;
- HTM 04-01: The Control of Legionella, hygiene, "safe" hot water, cold water and drinking water;
- HTM 06:01: Electrical services supply and distribution.

The AE audit report listed that the building services were in a satisfactory condition and recommended the continuation of ongoing maintenance works. Compliance assurance is monitored and recorded using a computerised maintenance management system.

The fire safety risk assessment was reviewed by a fire safety consultant on 11 October 2022 and action plan recommendations have been implemented in accordance with the specified time periods. Report risk evaluation was listed as `tolerable`. KPH estates management team confirmed on 30 May 2023 that action plan recommendations have been implemented.

The construction of a three storey extension is currently progressing adjacent the existing facility, access from the extension will be provided to the existing building via ground floor and first floor levels when the construction project is complete. Health and safety controls were implemented by the main contractor and provide assurance that health and safety protocols are maintained, keeping services users, staff, visitors and the general public safe during the construction works phase.

There were no AFI's required as a result of the estates inspector review.

5.2.5 Surgical Services/Theatres – Focus on Gynacological surgery

A review of surgery arrangements evidenced the theatres were operating effectively under their statement of purpose and categories of care. Staff reported that when scheduling theatre lists, the individual requirements of the patient; type of procedure performed; availability of equipment; staffing levels required; associated risks; and level of sedation used were all taken into account.

There was evidence that there was an identified member of nursing staff, with theatre experience, in charge of the operating theatre at all times and a permanent record was maintained, detailing the name of the nurse in charge of each theatre session. Review of documents and theatre records, which included the register for all surgical assistants' log and staff induction booklets, evidenced they did contain full names/signatures of staff.

It was confirmed that patient consented data is submitted to The Breast and Cosmetic Implant Registry (BCIR). The BCIR register was established to enable the identification of trends, complications relating to implants, and to ensure patients could be traced in the event of a product

recall or other safety concern. Consented patient data is submitted to a similar register for orthopaedic joint replacements.
It was confirmed that routine auditing of implant records is carried out to ensure compliance with the relevant directives.

The provision of sterile instrument packs and decontamination services are provided from Kingsbridge North West Private Hospital accredited sterile services department. There are three deliveries per day and the Theatre Manager confirmed this was sufficient to meet the needs of the surgical service. Robust measures were in place to monitor the traceability of all surgical instruments used in the hospital. It was noted clinical equipment in use and stored was clean and fit for purpose and traceability labels were used to identify when pieces of equipment had been cleaned.

It was observed that staff used a surgical safety checklist based on the World Health Organisation (WHO) checklist and complete the surgical checklist. However, it was noted that compliance with completion of this checklist is not currently being carried out. It was advised to recommence routine auditing to ensure compliance with the surgical safety checklist. The Theatre Manager gave assurances on this matter.

Staff and patients confirmed that the relevant Consultant Anaesthetist visited each patient prior to surgery to assess their general medical fitness; review their medication; explain the type of anaesthetic; discuss the procedure and discuss options for post-operative pain relief. It was confirmed that the Consultant Surgeon also visits the patient prior to surgery to discuss the procedure and obtain informed consent. A review of a sample of patient records evidenced these visits by the Consultant Anaesthetists and Consultant Surgeon.

Patients were observed during surgery and in the post anaesthetic care unit (PACU), and the hospital has discharge criteria in place to confirm when patients were well enough to transfer to the ward area. During the inspection PACU nursing staff confirmed one member of staff on duty in the unit had Cardiac Advanced Life Support (CALS) and the remaining staff had Immediate Life Support (ILS). It was noted Consultant Anaesthetists were present throughout the patient's surgery and on-site until the patient had recovered from the immediate effects of their anaesthetic. It was advised to ensure that at least one member of PACU nursing staff on duty has up to date ALS training. The Theatre Manager and RM provided assurances that this would be the case.

The surgical registers were reviewed for each theatre and were noted to be generally well completed. It was noted only the surnames of staff involved, such as the surgeon and nursing staff were being recorded in the register. It was confirmed the full names of non-consultant grade medical staff acting as surgical assistants were recorded. It was advised to record the full names of all staff in the surgical register. The Theatre Manager agreed to ensure full names are included in all future entries. This was actioned during the inspection.

The emergency trolley was located in theatre and in the PACU and checked daily by staff. A massive blood loss policy and procedure and a massive blood loss trolley was in place as stipulated in regional guidance 'Preventing transfusion delays in bleeding and critically anaemic patients' SHOT HSC SQSD 08/04/22. A massive blood loss drill involving theatre staff had recently taken place and staff reported this as being very beneficial.

There are robust arrangements in place for the collection, labelling, storage, preservation, transport and administration of specimens.

It was noted that a number of open trollies were located in the corridor area of the theatre suite and , these are used for the storage for single use equipment for categorised surgical procedures. This is not in keeping with IPC best practice and had also been highlighted in the findings of a recent IPC external audit. The frequency of cleaning of these trollies had been increased as a result of the IPC external audit findings and there was no evidence of dust on the trollies at the time of inspection. Assurance has since been received that these trollies will be replaced with closed portable storage units in accordance to IPC best practice.

5.2.6 Environment/Infection Prevention and Control

The environment and equipment were in a good state of repair, with a high standard of cleaning throughout. The general environment, wards and recovery were clean, clutter free and well organised to allow for effective cleaning of the environment. Hand sanitiser was available at all key points of care and hand hygiene practices observed by all disciplines were good. Hand washing facilities and a range of consumables were available to enable hand hygiene practices to be carried out effectively. Posters reinforcing the correct hand hygiene technique and use of personal protective equipment (PPE) were displayed appropriately at clinical hand wash sinks.

All staff working in the clinical area were compliant with current PPE guidance. All staff were compliant with 'bare below the elbow' practice and the hospital uniform policy while in clinical areas.

There were clear lines of accountability regarding infection control, and access to an external IPC advisor and microbiologist. Staff engaged with were unable to identify an IPC link champion but were aware of the escalation process for raising IPC concerns. The IPC link champion role had been in place on previous inspections to the hospital and this was considered to be an area of good practice, enabling staff with an interest in IPC to develop their knowledge to support and encourage colleagues to adhere to IPC best practice. This was discussed with the RM who confirmed a large number of new staff have recently been employed at the hospital and the IPC link champion role is currently being considered and will be allocated to relevant staff.

Cleaning schedules for both nursing staff and cleaning staff were available and complete.

Staff had good knowledge of IPC practices which included the symbol for single use, transmission based precautions, disinfectant solutions and the management of a needle stick injury.

Aseptic non-touch technique (ANTT) practice was not observed during the inspection but a number of staff were able to describe the process of scenarios given. Staff spoken with reported that whilst they had received ANTT training and competency assessment in the past, they had not had recent ANTT training and were not aware of any plans to provide updated competency assessment. This was discussed with the RM who confirmed an ANTT assessor is available within the hospital and plans are in place to provide refresher ANTT training and associated competency assessment for staff.

5.2.7 Staff Training

Review of documents provided evidence that staff are recruited and employed in accordance with relevant employment legislation and best practice guidance; relevant information had been sought and retained. Induction programmes were in place for new staff and staff reported they felt supported by the management team.

There were monitoring arrangements for mandatory training and staff confirmed that they have assigned training days. A number of medical staff spoken with confirmed that they had completed up to date mandatory training prior to commencing employment. Medical staff confirmed that this was a requirement prior to taking up their position and it was suggested that this requirement be added to the Practicing Privileges Policy for the hospital.

Review of the training matrix confirmed that since the previous inspection there was good improvement in staff compliance with mandatory training – for example, 91% of staff had received up to date basic life support training and almost 87% had received level 1&2 adult safeguarding protection training. Fire warden training has been added to the mandatory training schedule with an emphasis on all staff across the site requiring training.

A number of staff had not yet received up to date paediatric basic and immediate life support training (69.57% and 55.03% had received training respectively); some of these were newly recruited staff. Assurances were sought and received from the RM that there was a focus by the organisation on progressing these training programmes. Updated training figures received following the onsite inspection confirmed robust plans are in place to ensure all staff have receive the required mandatory training.

5.2.8 Laser

A review of laser services confirmed that laser and intense light source procedures are carried out by appropriately trained staff in accordance with best practice. The laser safety file was available for review during the inspection and staff spoken with demonstrated good knowledge on the safe management of lasers. There was mandatory written confirmation of the appointment and duties of a certified LPA which is reviewed on an annual basis.

A list of clinical authorised users is maintained and it was noted during the inspection that this was not signed off by all staff, to confirm that they have read and understood the local rules and medical treatment protocol. The authorised user's responsibilities were not detailed in the local rules and there was more than one copy of the local rules present. It was recommended to update the master copy of the local rules with amendments to ensure standardisation of documentation.

A review of patient records and the laser surgical register, confirmed that overall they were well completed. It was noted, there were gaps in record keeping completed by consultants, assurance has been provided that this has been addressed with medical staff.

Laser surgical eye procedures are carried out by trained medical practitioners in accordance with a medical treatment protocol produced by the consultant ophthalmologist. Systems are in place to review the medical treatment protocol on an annual basis.

The environment in which the laser equipment is used was found to be safe and controlled to protect other personnel when treatment is in progress. The controlled area is clearly defined and not used for other purposes, or as access to areas, when surgery is being carried out. It was noted on the day of the inspection that the laser safety warning sign had not been displayed for a previous eye laser procedure, staff advised that the current sign did not fit securely into the holder on the door. The RM confirmed that a new sign was on order, in the meantime, clear signage is to be displayed highlighting laser use, along with the illuminated sign when the laser equipment is in use and removed when not in use.

The door to the laser suite is locked when the laser equipment is in use but can be opened from the outside in the event of an emergency. The laser equipment is operated using a key. Arrangements are in place for the safe custody of the laser key when not in use.

Protective eyewear is available as outlined in the local rules for the laser nurse if required.

A laser safety file was in place which required review to ensure that all documents were up to date and old or discontinued documents removed for archiving.

Laser safety training records were reviewed which indicated three staff members had not completed laser safety training within the last five years, additionally, a number of consultants require renew training prior to expiry in October 2023. The RM confirmed training dates in June 2023, for staff who's training had expired or was about ot expire.

Some practical areas for follow up were provided on the day, including minor adjustments to the local rules, laser policies and grab sheet. Evidence has been provided by the RM to confirm that all areas for follow up have been actioned.

There are arrangements in place to service and maintain the laser equipment in line with the manufacturer's guidance.

The LPA for RQIA provided a report of the laser safety arrangements for the laser eye surgery service which is appended to the report.

Laser Protection Report

Site Details:

Kingsbridge Private Hospital
811-815 Lisburn Road
Belfast
BT9 7GX

Laser Protection Adviser appointed by site:

Anna Bass, Lasermet

Laser/IPL Equipment:

Make	Model	Class	Serial Number	Wavelength(s)
Lumenis	Aura PT	3B	YA44-0165	1064nm (Nd:YAG)

Introduction

A Laser Protection Adviser inspection of Kingsbridge Private Hospital was performed on 16 March 2023. This report summarises the main aspects of the inspection and document review where improvements may be required. The findings are based on the requirements of the Minimum Care Standards for Independent Healthcare Establishments published July 2014 by the Department of Health, Social Services and Public Safety (DHSSPSNI) and other relevant legislation, guidance notes and European Standards.

The LPA inspection included a review of:

- Protective eyewear
- Environment/signage
- Training records and user authorisation
- Laser device markings
- Maintenance Records
- Treatment protocols
- Risk assessments
- Local Rules
- Appointment of duty holders (LPS/LPA)

Comments / Recommendations:

1. Laser Room: On the day of inspection it was noted that the laser sign had not been displayed on the door during the previous laser case and there was an x-ray sign on the door to the laser room. The clinic should ensure that staff are familiar with the Local Rules and the correct signage to demarcate the laser controlled area.

2. Local Rules

The following updates required to the local rules were discussed with the clinic on the day of inspection for remedial action:

a. The Authorised User's responsibilities should be detailed in the Local Rules.
b. The Laser Protection Adviser should be asked to review the Protective Eyewear section to ensure that the eyewear markings correspond with the EN207 scale numbers in the eyewear rationale document.

3. Register of Authorised Users and Register of Laser Assistants

The following points relating to the Register of Authorised Users and Register of Laser Assistants were discussed with the clinic on the day of inspection for remedial action:

a. The lead clinician had not signed against all the Authorised Users to confirm that they had received adequate training.
b. There were four laser assistants who had not signed the Register of Laser Assistants.
c. The signatures on the Register of Authorised Users and Register of Laser Assistants were collected in copies that was separate from the Master Copy of the Local Rules. In accordance with the Local Rules, signatures should only be collected in the Master Copy.

4. Grab Sheet: The grab sheet should be reviewed to ensure that the information detailed is correct and updated accordingly.

5. Treatment Register (Log book): It was noted that the laser parameters were not fully completed in the treatment register for all records. This was discussed with the clinic, and they indicated they will advise the consultants on the importance of record keeping and ensuring the treatment register is fully completed.

6. Laser Safety Training: On the day of the inspection, three staff members on the register of laser assistants had not completed laser safety training within the last 5 years. The clinic should ensure that these staff are provided with laser safety training.

It was also noted that some consultants would need to renew their laser safety training prior to expiry in October 2023. This was discussed with the clinic and they will be organising training for staff.

7. Laser Safety File: The laser safety file should be reviewed to ensure that the documents are all up to date, and old or discontinued documents should be removed or placed in an archive section.

The clinic should inform RQIA when the above points have been addressed.

Post Inspection Update: The clinic has provided the following updates:

Point 1. The clinic has ordered new door signage and have advised that in the meantime staff are to ensure that laser use is noted on the door along with the illuminated sign.

Point 2. The clinic has provided updated Local Rules and this point has been satisfactorily resolved.

Point 3. The clinic has advised that this point is currently being addressed.

Point 4. The clinic has provided updated grab sheet and this point has been satisfactorily resolved.

Point 6. The clinic has advised core of knowledge training has been organised for the 19 June 2023.

Mrs Jane Brown
Laser Protection Adviser to RQIA

6.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no AFI's being identified. Findings of the inspection were discussed with Ms Kelly Macartney, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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

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