Announced Care Inspection Report
12 & 13 September 2017

Kingsbridge Private Hospital

Type of Service: Independent Hospital – Surgical Services
Address: 811-815 Lisburn Road, Belfast BT9 7GX
Tel No: 02890667878
Inspectors: Winifred Maguire & Norma Munn
RQIA's Medical Physics Advisor: Dr Ian Gillan

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

2.0 Profile of service

This is a registered independent hospital providing surgical, endoscopy, laser, outpatients, minor injury and radiology services. There are 16 registered overnight beds and six day procedure beds.

Laser equipment

- Manufacturer: Lumenis
- Model: Aura PT
- Serial Number: YA44-0165
- Laser Class: 3B

Laser protection advisor (LPA):

- Ms Anna Bass (Lasermet)

Laser protection supervisor (LPS):

- Mrs Aisling Green

Clinical authorised users:

- Five named consultant Ophthalmologists

Types of treatment provided:

- Laser capsulotomy procedure

3.0 Service details

Organisation/Registered Provider: 3fivetwo Medical Ltd **Responsible Individual(s):** Mr Mark Regan	**Registered Manager:** Mrs Sarah Marks
Person in charge at the time of inspection: Mrs 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 - case beds

4.0 Inspection summary

An announced inspection took place on 12 September 2017 from 09.50 to 16.45, and 13 September 2017 from 09.30 to 16.00.

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

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

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the establishment was delivering safe, effective and compassionate care, and if the service was well led.

Examples of good practice were evidenced in all four domains. These related to: patient safety in respect of staff training and development; recruitment; safeguarding; laser safety arrangements; the provision of surgical services; resuscitation arrangements and the management of medical emergencies; infection prevention control; and the environment. Other examples included: the management of the patients' care pathway; communication; records management, practising privileges arrangements and engagement to enhance the patients' experience.

There were no areas of improvement identified.

Patients who spoke with the inspectors were very satisfied with the services provided in Kingsbridge Private Hospital. Comments provided included the following:

- "Very well informed about every aspect of my surgery."
- "Couldn't be better."
- "Everything was 100 per cent."
- "Staff were excellent."

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Sarah Marks, registered manager and Ms Brenda Partridge, governance manager as part of the inspection process, and can be found in the main body of the report.

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

4.2 Action/enforcement taken following the most recent care inspection dated 28 – 29 September 2016

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 28 – 29 September 2016

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 since the previous care inspection
- duty calls
- the registration status of the establishment
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report
- submitted complaints declaration

Questionnaires were provided to patients and staff prior to the inspection by the establishment on behalf of RQIA. Returned completed patient and staff questionnaires were also analysed prior to the inspection.

A poster informing patients that an inspection was being conducted was displayed.

During the inspection the inspectors met with four patients and two relatives. The following staff were also spoken with during the inspection:

- Mr Mark Regan, registered person
- Mrs Sarah Marks, registered manager
- Ms Brenda Partridge, governance manager
- the theatre manager
- a theatre sister
- two theatre health care assistants
- two ward nurses
- a nurse involved in the laser service
- a patient safety nurse
- a primary care nurse
- a resident medical officer
- briefly with a clinical cardiac physiologist

A tour of the premises was also undertaken.

A sample of records was examined during the inspection in relation to the following areas:

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

- management and governance arrangements
- maintenance arrangements

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

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 28 – 29 September 2016

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

6.2 Review of areas for improvement from the last care inspection dated 28 – 29 September 2016

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Minimum Care Standards for Independent Healthcare Establishments (2014)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 48.11 **Stated:** First time	Discuss the findings of the laser risk assessment and the most recent laser protection advisor (LPA) report with the hospitals LPA and take action as necessary.	**Met**
	Action taken as confirmed during the inspection: Evidence was provided that a visit by the hospital's laser protection advisor had been scheduled for 26 September 2017 to update the risk assessment and the local rules. Assurances were given by management that any necessary action as a result of this visit would be carried out.	
Area for improvement 2 **Ref**: Standard 48.2 **Stated:** First time	Maintain a complete register of authorised users who sign they have read and understood the local rules and medical treatment protocols.	**Met**

	Action taken as confirmed during the inspection: A register of authorised operators was in place. A review of the register evidenced that the authorised operators had signed that they had read and understood the local rules and the medical treatment protocol.	
Area for improvement 3 **Ref**: Standard 48.9 **Stated:** First time	Fully complete all fields of the laser register and establish an audit on the completion of the laser register.	**Met**
	Action taken as confirmed during the inspection: The laser register was reviewed and found to be accurately completed. An audit in relation to the completion of the register was in place.	
Area for improvement 4 **Ref**: Standard 48.20 **Stated:** First time	The laser classification label was hidden behind the side leaf of a laser table; this matter should be discussed with Sigmacon (supplier) and an additional label obtained and attached to the laser.	**Met**
	Action taken as confirmed during the inspection: The classification label was noted to be attached to the laser machine in a visible position.	
Area for improvement 5 **Ref**: Standard 48.12 **Stated:** First time	Provide evidence all authorised users of the laser have undertaken application training and have undertaken a core of knowledge update in the last five years.	**Met**
	Action taken as confirmed during the inspection: There was evidence that all authorised operators had application training and have undertaken a core of knowledge update in the last five years.	
Area for improvement 6 **Ref**: Standard 48.12 **Stated:** First time	Practising privileges agreements should specify the scope of practice for each medical practitioner for which practising privileges are granted.	**Met**
	Action taken as confirmed during the inspection: A review of five practising privileges' agreements found that the scope of practice was included for each medical practitioner.	

Area for improvement 7 **Ref**: Standard 16.11 **Stated:** First time	The whistleblowing policy should be further developed to include reference to the various professional bodies that staff may refer to if appropriate. The details of Public Concern at Work should also be included as an avenue for staff advice and support.	**Met**
	Action taken as confirmed during the inspection: The whistleblowing policy was noted to contain references to relevant professional bodies and Public Concern at Work.	

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

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

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

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

Procedures were in place for appraising staff performance, and staff confirmed that appraisals had taken place. Staff confirmed they felt supported and involved in discussions about their personal development. Review of a sample of four evidenced that appraisals had been completed; however, two were dated for 2015. Management gave assurances that appraisals were ongoing and some records had not been yet retained in the individual staff records. Staff spoken with also confirmed they had had an appraisal in the last year.

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

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

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

The hospital affords staff opportunities to undertake specialist qualifications such as intravenous medication administration, peripheral cannulation, urinary catheterisation and 'right patient right blood'.

Mrs Marks explained that the hospital promoted individual continuing professional development (CPD) plans and funded short courses (one day) and lengthier courses on an annual basis. Staff are encouraged to apply for funding and it was confirmed a fair and equitable selection process is in place on the matter.

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

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

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

It was confirmed that each medical practitioner has an appointed responsible officer.

Recruitment and selection

It was confirmed that four staff have been recruited since the previous inspection. A review of the personnel files for these staff demonstrated that all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained.

An additional staff member's file had been reviewed as a new member of staff. However, during the inspection it was clarified that this staff member was not a new member of staff, and had in fact been a permanent member of nursing staff before moving to the bank nursing team and then resuming a permanent nursing post. The documentation reviewed did not fully reflect this continuity of employment. Further written assurances were provided during the inspection by the group human resources manager on the continual employment status of this individual in Kingsbridge Private Hospital. Advice was given on providing total transparency when documenting staff employment, and ensuring the staff register is in accordance with each staff member's current employment status in the hospital.

There was a recruitment policy and procedure available. Minor amendments were made during inspection and it was found to be comprehensive and reflected best practice guidance.

Surgical services

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

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

The scheduling of patients for surgical procedures is co-ordinated by the clinical administrative manager and her team based in 3fivetwo offices in Titanic Quarter in consultation with the surgeons. The theatre manager confirmed she is directly involved in reviewing the scheduling and can make changes if necessary. The theatre lists take into account the individual requirements of the patient, the type of procedure to be performed, availability of equipment, staffing levels required, associated risks and level of sedation to be used.

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

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

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

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

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

On discussion staff confirmed that the surgical safety checklist based on the World Health Organisation (WHO) model is used in the hospital. Completion of the surgical safety checklists is audited as part of the hospitals comprehensive clinical governance systems. Review of the audits confirmed that a high compliance rate is achieved.

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

- prevention of intra –operative hypothermia
- intra-operative fluid management
- mass blood loss in theatre
- emergency line’s box
- nurse in charge of theatre
- anaesthetist’s role
- regional labelling of invasive lines and tubes
- cleaning of theatres including deep cleaning

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

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

A review of two surgical registers of operations, which are maintained for all surgical procedures undertaken in the hospital, found that they contained all of the information required by legislation.

Laser Safety

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

There was written confirmation of the appointment and duties of a certified laser protection advisor (LPA) which is reviewed on an annual basis. A letter from the hospital's LPA was submitted to RQIA following the inspection confirming her appointment as the LPA for the hospital in advance of issuing a LPA support certificate.

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

Evidence was provided during the inspection that a visit by the hospital's laser protection advisor had been scheduled for 26 September 2017 to update the risk assessment and the local rules. Assurances were given by management that any necessary action as a result of this visit would be carried out.

A list of clinical authorised operators is maintained and authorised operators have signed to state that they have read and understood the local rules and the medical treatment protocol.

When the laser equipment is in use, the safety of all persons in the controlled area is the responsibility of the laser protection supervisor (LPS). Arrangements are in place for another authorised operator to deputise for the LPS in their absence, who is suitably skilled to fulfil the role. Discussion with a nurse confirmed that systems are in place to ensure other authorised operators are aware who is the LPS on duty.

The environment in which the laser equipment is used was found to be safe and controlled to protect other persons while 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.

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.

Laser safety warning signs are displayed when the laser equipment is in use and removed when not in use.

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

The establishment has a laser surgical register which is completed every time the equipment is operated and includes:

- the name of the person treated
- the date
- the operator
- the treatment given
- the precise exposure
- any accident or adverse incident

A review of the laser surgical register during the inspection found it to be comprehensively completed.

There are arrangements in place to service and maintain the laser equipment in line with the manufacturer's guidance. The most recent service report dated April 2017 was reviewed as part of the inspection process.

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

Dr Ian Gillan, RQIA's Medical Physics Advisor, reviewed the laser safety arrangements for the laser eye surgery service; the findings and report of Dr Gillan is appended to this report.

Safeguarding

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

Review of records demonstrated that all staff in the establishment had received training in safeguarding children and adults as outlined in the Minimum Care Standards for Independent Healthcare Establishments July 2014, and in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016).

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

Resuscitation and management of medical emergencies

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

An emergency trolley located in ward 2 was reviewed and found to contain all the necessary equipment. It was confirmed that the emergency medicines are checked by the hospital pharmacist who then seals and tags the emergency medicine box.

It was noted that an emergency trolley, located in the outpatients department within the cardiac investigation room, had a number of steps leading to it from the outpatients department. The accessibility of this emergency trolley was discussed and an outside transfer route was later described by management. However, staff also confirmed that if a medical emergency occurs in the outpatients department, the emergency call bell will immediately summon the emergency hospital team, who will take the emergency trolley from the recovery ward to the emergency situation. It was suggested that all staff working in the outpatients have a full understanding of the arrangements to access an emergency trolley.

A review of training records and discussion with staff confirmed that staff have undertaken basic life support training and updates, and some nursing staff had received immediate life support training and updates. There is always at least one staff member with advanced life support training on duty at all times. The resident medical officer confirmed he had undertaken advanced adult and paediatric life support training.

Staff involved in the provision of paediatric care have paediatric life support training and updates. When children are admitted for treatment there is at least one staff member on duty trained in paediatric advanced life support.

Discussion with staff in relation to the arrangements regarding patients with a “Do Not Resuscitate” (DNR) order in place confirmed that patients who have a DNR order in place would not meet the admission criteria for the hospital and would not be admitted.

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

The policy for the management of medical emergencies reflected best practice guidance. Protocols were available for staff reference outlining the local procedure for dealing with the various medical emergencies. It was noted the resuscitation equipment policy referred to the vanguard theatre which is no longer in use in the hospital. The policy was amended during the inspection to remove the reference to the vanguard theatre.

Infection prevention control and decontamination procedures

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

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

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

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

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

A range of IPC audits have been carried out including:

- environmental
- hand hygiene

- surgical site infection

In additional an IPC audit had been carried by the hospitals IPC external advisor. There was an action plan included however, the action plan had not been signed off. It was therefore unclear if the matters highlighted had been actioned. Discussion took place on this matter and following the inspection evidence was submitted to RQIA confirming the action plan had been assigned to individual staff for action. In addition this and subsequent IPC audits and action plans, will be a recurring item on the monthly management meetings to ensure a robust follow up.

A surgical site infection (SSI) log was not available for inspection. Immediately following the inspection a completed SSI log was forwarded to RQIA.

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

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

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

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

Environment

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

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

A review of documentation and discussion with management and staff demonstrated that arrangements are in place for maintaining the environment.

A RQIA estates inspection had been conducted in 2016.

A fire risk assessment had been undertaken and staff confirmed fire training and fire drills had been completed. Staff demonstrated that they were aware of the action to take in the event of a fire.

Patient and staff views

Five patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm. Four patients indicated that they were very satisfied with this aspect of care and one indicated that they were satisfied. Comments provided included the following:

- “Cleaner than the NHS equivalent.”
- “Calm environment and staff attentive.”

Nine staff submitted questionnaire responses. All indicated that they felt that patients are safe and protected from harm. Six staff indicated that they were very satisfied with this aspect of care and three indicated that they were satisfied. Staff spoken with during the inspection concurred with this. Comments provided included the following:

- "The premises need updated and more up to date equipment required, furniture, obs machine."
- "We have just started appraisals and this is ongoing."

The above comment was discussed with Mrs Sarah Marks who confirmed that the hospital was currently trialling new observation equipment with a view to replacing all such equipment in the future.

Areas of good practice

There were examples of good practice found in relation to staff recruitment; induction; training; supervision and appraisal; safeguarding; surgical services; resuscitation and management of medical emergencies; infection prevention control; radiology and the environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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. Copies of the patient guide are made available to all patients following admission.

Five patient records reviewed found that the care records contained comprehensive information relating to pre-operative, peri-operative and post-operative care, which clearly outlined the patient pathway and included the following:

- patient personal information
- holistic assessments
- pre-operative care plans
- pre-operative checks
- signed consent forms
- surgical safety checklist
- operation notes
- anaesthetic notes
- medical notes
- intra-operative care plans
- recovery care plans
- post-operative care plans
- multidisciplinary notes
- daily statement of the patient's condition
- discharge plan

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

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

- "I have been well looked after."
- "Very impressed by everyone here."
- "Given clear information, I could ask questions if I wanted to."
- "Staff checked how I was doing regularly during the night."

Records

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

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

The establishment is registered with the Information Commissioner's Office (ICO).

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

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

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

Discharge planning

The hospital has a discharge policy and procedure in place.

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

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

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

Patient and staff views

All patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them. Four patients indicated that they were very satisfied with this aspect of care and one indicated that they were satisfied. The following comment was provided:

- "Information provided at all times."

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

- "All staff complement one another - excellent interpersonal skills. Great teamwork."

Areas of good practice

There were examples of good practice found in relation to completion of clinical records, the arrangements for records management and ensuring effective communication between patients and staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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.

Dignity, respect and rights

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

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

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

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

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

- "Staff were very aware of my modesty."
- "Always treated with respect and compassion."

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

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

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

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

Breaking bad news

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

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

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

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

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

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

Patient consultation

The establishment obtains the views of patients and/or their representatives on a formal and informal basis as an integral part of the service they deliver.

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

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

- "Five star all round."
- "They looked after me so well."
- "I came via the cross border directive. I will be recommending the place to the whole town. Outstanding care."

The information received from the patient feedback questionnaires is collated into an annual summary report which is made available to patients and other interested parties to read within the establishment and on the establishment's website.

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

Patient and staff views

All patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care. Four patients indicated that they were very satisfied with this aspect of care and one indicated that they were satisfied. The following comment was provided:

- "A double gown was provided."

All submitted staff questionnaire responses indicated that they felt that patients are treated with dignity and respect and are involved in decision making affecting their care. Eight staff indicated that they were very satisfied with this aspect of care and one indicated that they were satisfied. Staff spoken with during the inspection concurred with this. No comments were included in submitted questionnaire responses.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to maintaining patient confidentiality, 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
Total number of 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.

Management and governance arrangements

There was a clear organisational structure within the hospital and staff were able to describe their roles and responsibilities and were aware of who to speak to if they had a concern. Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Mrs Marks, registered manager, has overall responsibility for the day to day management of the hospital. Mr Regan, registered provider confirmed his office is on the Kingsbridge Hospital site and he is kept informed as to the operation of the hospital on an ongoing basis.

Systems were in place to ensure that the quality of services provided by the hospital is evaluated on an annual basis and discussed with relevant stakeholders. The hospital has a robust medical advisor and clinical governance committee involving all areas of the hospital service. This committee receives a quarterly governance report. There is a governance manager in place. Monthly quality team meeting are held. Mrs Marks confirmed weekly management meetings involving departmental leads and managers are also held.

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

Arrangements were in place to review risk assessments.

A copy of the complaints procedure was available in the hospital and is included in the patient information pack. Staff demonstrated a good awareness of complaints management. A complaints questionnaire was forwarded by RQIA to the hospital for completion. The evidence provided in the returned questionnaire and review of a random sample of six complaint investigation records indicated that complaints have been managed in accordance with best practice.

Mrs Marks and Ms Partridge confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals. If required an action plan is developed and embedded into practice to address any shortfalls identified during the audit process.

The following audits were reviewed:

- YAG laser compliance
- post -operative nausea and vomiting
- hip outcomes
- crash trolley
- general surgery
- infection rate
- orthopaedic
- complaints

- hand hygiene
- surgical safety checklist
- theatre documentation
- urethral catheter documentation
- infection prevention and control internal and external audit
- patient identification
- venous thromboembolism (VTE) risk assessment

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

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

Mrs Marks outlined the process for granting practising privileges and confirmed medical practitioners' full application is reviewed by the medical advisor committee prior to privileges being granted.

Five medical practitioners' personnel files were reviewed and confirmed that there was a written agreement between each medical practitioner and the establishment setting out the terms and conditions of practising privileges, including the scope of practice, which has been signed by both parties.

There are systems in place to review practising privileges agreements every two years.

A policy and procedure is in place which outlines the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges.

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

Mr Regan and Mrs Marks demonstrated a clear understanding of their roles and responsibilities in accordance with legislation. Information requested by RQIA has been submitted within specified timeframes. It was confirmed that the statement of purpose and patient's guide are kept under review, revised and updated when necessary and available on request.

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

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

Patient and staff views

All patients who submitted questionnaire responses indicated that they felt that the service is well led. Four patients indicated that they were very satisfied with this aspect of the service and one indicated that they were satisfied. No comments were included in submitted questionnaire responses.

All staff questionnaire responses indicated that they felt that the service is well led. Seven staff indicated that they were very satisfied with this aspect of the service and two indicated that they were satisfied. Staff spoken with during the inspection concurred with this. The following comment was provided:

- "My ward manager is excellent – approachable and fully supportive."

Areas of good practice

There were examples of good practice found in relation to the management of complaints and incidents; practising privileges arrangements; quality improvement and governance arrangements; and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

13th September 2017

Mrs Maguire
Regulation & Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Dear Mrs Maguire

Laser Protection Report

KINGSBRIDGE PRIVATE HOSPITAL, 811-815 LISBURN ROAD, BELFAST, BT9 7GX

Introduction
Further to yesterday's inspection of the above premises, this report summarises the main laser protection aspects where improvement may be required. The findings are based on the requirements of current legislation, relevant guidance notes and European Standards.

Deficiencies / Comments
(1) Laser Support certificate/contract with Lasermet:- The certificate available on the inspection day was not valid after October 2016. The Hospital should confirm whether a current contract is in place and if so obtain a valid certificate as evidence of these arrangements.

(2) The Hospital should also contact their Laser Protection Adviser (LPA) in order to update the following documents or confirm that the current versions dated 2015 are still valid:-

- Local Rules
- Risk assessment for the use of the laser system

(3) LPA Report:- The Hospital should obtain a report from their LPA confirming that the laser safety arrangements are satisfactory or providing an action list to address any deficiencies. The LPA normally carries out a site visit to assess these arrangements and then provides a written report.

(4) Laser Safety File:- The file should be restructured to enable current versions of relevant documents to be easily viewed. Previous versions of documents should be placed in an archive file when documents are updated. It would be appropriate for the Hospital to seek advice from their LPA when reorganising the file.

Ian Gillan

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Dr Ian Gillan
Laser Protection Adviser for RQIA

APPENDIX 1

KINGSBRIDGE PRIVATE HOSPITAL
811-815 LISBURN ROAD, BELFAST, BT9 7GX

Laser System

Laser Medium	Nd:YAG Laser
Laser Class:	3B
Model:	Aura PT
Manufacturer:	Lumenis
Serial no.:	YA44-0165

Laser Protection Adviser

Anna Bass, Lasermet

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
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BT1 3BT

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