The Regulation and Quality Improvement Authority

Inspection Report

15 February 2022

Kingsbridge Private Hospital

Type of Service: Independent Hospital (IH)
Kingsbridge Private Hospital
811-815 Lisburn Road
Belfast
BT9 7GX

Tel No: 028 9066 7878

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/ https://www.rqia.org.uk/The Independent Health Care Regulations (Northern Ireland) 2005 and Minimum Care Standards for Independent Healthcare Establishments (July 2014)

1.0 Service information

Organisation/Registered Provider: Kingsbridge Healthcare Group Limited **Responsible Individual:** Mr Mark Regan	**Registered Manager:** Ms Sarah Marks **Date registered:** 10 December 2013
Person in charge at the time of inspection: Ms Sarah Marks	**Number of registered places:** 24 (including two Intensive Care Unit post-cardiac surgery 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 (KPH) 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; a dedicated endoscopy suite; 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 also the first independent sector provider in Northern Ireland, to register a critical care service providing intensive care unit accommodation for post-cardiac surgery patients as specified on their registration condition i.e. aortic valve replacement; coronary artery bypass graft; mitral valve replacement; atrial myxoma and adult atrial septal defect.	

2.0 Inspection summary

An unannounced inspection took place in Kingsbridge Private Hospital (KPH) on 15 February 2022 and concluded on 24 February 2022 with feedback to the manager, Ms Sarah Marks and members of the senior management and governance teams.

The hospital was inspected by a team comprised of care inspectors, a medical practitioner and by an estates inspector who provided support remotely.

This inspection focused on eight key themes: governance and leadership; patient care records; surgical services/theatres; nursing care; safeguarding; staffing; environment and IPC; and estates. The inspection also sought to assess progress with any areas for improvement identified within the quality improvement plan (QIP) from the last inspection to KPH on 11 and 12 October 2021. Additionally, the inspection sought to review the patients' journey when admitted to the hospital for cardiac surgery as defined by the registration condition.

The inspection team met with a range of staff, including managers, nursing and medical staff, catering staff, domestic services staff and allied health professionals (AHPs); and reviewed aspects of frontline care and practices and the management and oversight of governance across the organisation.

It was established KPH have robust governance and oversight mechanisms to provide assurances relating to medical and clinical governance, management of incidents and care delivery. There was evidence of effective communication systems to ensure staff and patients received key information. It was noted staff knowledge was good in relation to safeguarding, application of the World Health Organisation (WHO) surgical checklist, and the assessment and management of pain.

Patients told us they were happy with the care and advice or guidance provided to them by the hospital staff.

Two areas for improvement (AFI) identified during previous inspections were reviewed and an assessment of achievement was recorded as met for each. Three new areas for improvement were identified during this inspection; one relating to mandatory training for staff; one relating to effective record keeping and documentation of patient records; and one relating to the completion of risk assessment for patients returning to the ward from intensive care unit (ICU) who are deemed to no longer require the support of an ICU nurse.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our 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 our 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;
- the 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 practices and examined records in relation to each of the areas inspected and met with the registered manager, members of the multidisciplinary team (MDT) and the senior management and governance team.

Experiences and views were gathered from staff and patients.

Areas for improvement 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 our inspection were displayed while the inspection was in process. Staff and patients were invited to complete an electronic questionnaire during the inspection.

No patient questionnaires were received by RQIA. The feedback from patients during the inspection indicated that they were very 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.

Several interviews with medical, nursing and AHP staff were conducted. These interviews included staff from three wards, theatres and the recovery ward. Staff provided positive feedback indicating that they were very happy in their roles; they felt well supported by management and had good lines of communication. No electronic staff questionnaires were received by RQIA.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to KPH was undertaken on 11 and 12 October 2021 by a team of inspectors and two new areas for improvement were identified.

Areas for improvement from the last inspection on 11 and 12 October 2021		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 15(1) **Stated:** First time	The Responsible Individual shall ensure the safe and ongoing care for post-operative cardiac patients in Kingsbridge Private Hospital (KPH) by establishing a memorandum of understanding (MOU) with the Belfast Health and Social Care Trust (BHSCT) to include the arrangements for the transfer out of post-cardiac surgical patients to the BHSCT based on medical assessment.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 5.3.1.	
Area for improvement 2 **Ref:** Regulation 15(6) **Stated:** First time	The Responsible Individual shall provide written confirmation from the Department of Health (DoH) of the final approval of the controlled drugs (CD) licence for the new entity.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail is provided in section 5.3.1.	

5.2 Inspection findings

5.3 Governance and Leadership

5.3.1 Clinical and Organisational Governance

There was effective management and governance systems in place at the hospital to ensure the overall quality and safety of the services provided.

There was a clear organisational structure and accountability arrangements within the hospital. These arrangements were demonstrated by the holding of various meetings, such as weekly management meetings, weekly ICU meetings, and monthly Clinical Governance meetings, through which assurances were provided to the Responsible Individual. There was a nominated individual with overall responsibility for the day to day management of the hospital. Staff were able to describe their role and responsibilities and confirmed that there were good working relationships with managers, who were responsive to any suggestions or concerns raised.

In line with Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments (2014) clinical governance within KPH was overseen by The Medical Advisory Committee (MAC) which meets every quarter, with arrangements in place for extraordinary meetings where necessary. Minutes of meetings confirmed that all relevant agenda items are covered at these meetings, for example, clinical governance issues, performance indicators, and corrective action in relation to adverse clinical incidents. In addition to these meetings monthly morbidity and mortality meetings have been commenced, focussing on speciality driven themes.

Systems were in place to ensure that the quality of services provided by the hospital is evaluated on an ongoing basis. Regular audits undertaken included audits of venous thromboembolism (VTE) risk assessments, infection prevention and control (IPC), surgical safety checklists, fluid balance charts and prescription charts. A clear system was in place that addressed areas of non-compliance. An additional level of assurance to the internal monitoring of IPC practices is provided by validation audits undertaken by the external IPC advisor.

Two areas for improvement resulting from the inspection to KPH on 11 and 12 October 2021 were reviewed during this inspection and confirmed as met. A copy of the signed memorandum of understanding (MOU) with the Belfast Health and Social Trust (BHSCT) was submitted to RQIA following the inspection in October 2021 which confirmed arrangements were in place for the transfer out of post-cardiac surgical patients to the BHSCT based on medical assessment. Medical staff engaged with confirmed that they were aware of the signed MOU with BHSCT and of the arrangements in place between the two organisations. Similarly, an in date copy of the Controlled Drug (CD) licence was submitted to RQIA following the inspection in October 2021, this licence was available for examination during the latest inspection.

Examination of insurance documentation confirmed that insurance policies were in place.

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

5.3.2 Practising Privileges

The hospital has a policy and procedure in place, which outlines the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges. There are systems in place 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. Review of several personnel files of medical practitioners including consultant surgeons, anaesthetists ,surgical assistants and resident medical officers (RMO) confirmed that all relevant documentation was present in relation to professional indemnity, insurance and medical appraisals.

5.3.3 Communication

Policies and procedures were available for staff reference and they were dated and systematically reviewed. Staff told us they were aware of the policies and on request they effectively demonstrated how to access them.

There were systems in place to promote effective communication with all staff. We reviewed evidence of regular staff meetings, daily staff briefs are held and information is disseminated to staff directly from managers and by the use of learning boards. All staff reported how they received feedback and learning via staff meetings, emails, minutes, text messages, directly from managers and via the learning board. A good example of patient safety communication sharing was observed on the staff learning board which displayed the 'learning Matters October 2021 edition', in relation to a Safety and Quality Reminder of Best Practice Guidance Letter 'Risk of serious harm or death from choking on foods'. This communication was supplemented by the development of a dysphagia awareness pack by the Nurse Clinical Lead bespoke to the hospital and shared with all staff.

5.3.4 Complaints Management

Copies of the complaints procedure and whistleblowing policy were available and staff demonstrated a good awareness of both. Complaints can be received by a number of different methods, verbally or by letter/email for example, and a complaints investigation is commenced. Information recorded for complaints included nature, type of complaint, department involved, clinical speciality involved, risk rating, outcome and complainant satisfaction and whether response timescales were met.

There was clear evidence of the introduction of learning and changes from complaint analysis. Assurance was sought of actions taken by the hospital following a number of complaints relating to financial reimbursement for cross border patients as a result of coding issues for surgical procedures. The hospital has identified a re-occurring issue with one code and has reviewed its coding process. Additionally, the hospital has employed a patient liaison officer who plays an active role in managing complaints in the hospital.

5.3.5 Notifiable Events/Incidents

Systems were in place to support good risk management within the hospital. This ensures that the chances of adverse incidents, risks and complaints are minimised by effective risk identification, prioritisation, treatment and management.

Adverse incident reporting is done electronically and enables the quick analysis of incident data and provides actionable trend intelligence that can be reported in real-time, reducing delays experienced with the previous paper based system. In line with statutory requirements there was evidence to confirm that the hospital reported any notifications of deaths or other incidents to RQIA within appropriate timescales. The hospital also voluntarily reports to the Northern Ireland Adverse Incident Centre (NIAIC) which promotes the safety of service-users and investigation of adverse incidents involving medical devices, non-medical equipment, plant and building elements and provides relevant safety guidance in relation to these areas.

Systems are in place for staff to review alerts and confirm they have read them.

A monthly summary of adverse clinical risks are presented as part of the governance report to the clinical governance committee.

5.4 Patient Care Records (medical and nursing)

The hospital is registered with the Information Commissioner's Office (ICO). Records required by legislation were retained and were available for inspection at all times.

A review of a sample of patient records evidenced 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. Care records contained information relating to pre-operative, peri-operative, and post-operative care which clearly outlined the patient pathway.

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. Some minor discrepancies in relation to documentation and filing were identified and brought to the attention of senior staff who agreed to action.

Patient care records were held in a secure environment. Computerised records were accessed using individual usernames and passwords.

5.5 Surgical Services/Theatres

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 not consistently contain full names/signatures of staff. These issues were brought to the attention of the nurse in charge of theatres and it was reassuring to note that prompt actions were taken to address.

Whilst work had progressed with Health and Social Care (HSC) Trusts in relation to the submission of patient consented data to be included in on The Breast and Cosmetic Implant Registry (BCIR), it was evident that further work was required, this was brought to the attention of senior staff and actioned during the inspection. 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.

There were links to contracts with accredited Trusts' sterile services departments for the provision of sterile instrument packs and also decontamination services. 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.

There was evidence staff used a surgical checklist based on the WHO checklist and completion of the surgical checklist and compliance was routinely audited and monitored as part of the hospital's clinical governing system.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. Systems were in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. There was evidence that medicine refrigerators contents and temperatures were checked. The emergency trolleys were accessible and their contents checked at regular intervals to ensure that equipment was in working order and perishable items were in date.

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; obtain informed consent; and discuss options for post-operative pain relief. A review of a sample of patient records evidenced these visits by the Consultant Anaesthetists. 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.

Patients were observed during surgery and in the recovery room, and the hospital had discharge criteria in place to confirm when patients were well enough to leave theatre recovery and to transfer to the ward area.

5.6 Nursing Care (nutrition and hydration, pain management and compassion)

There was evidence of the delivery of safe, effective and compassionate nursing care observed throughout the hospital.

Patients had a good choice of meals and were able to request snacks, a choice of fluids and smaller meal portions using the menu provided by the hospital. Meal times were protected and patients were monitored during meal times to ensure they received any required assistance. Care records evidenced patient daily fluid intake was recorded where required. There were no patients that required food intake monitoring at the time of the inspection. Patient feedback was excellent in relation to food quality and menu choices.

There were communication systems in place between nursing staff and catering staff that ensured individual patient dietary needs, including allergies and requirements for a modified texture diet, were shared.

Weight, height, and body mass index (BMI) were recorded within the patients' care records. It was noted a malnutrition screening tool was not used to identify malnutrition and those at risk of malnutrition. This was discussed with the patient safety nurse and at feedback to the senior management team who agreed to review.

There were good patient pain management records and it 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 told us of excellent links with the MDT to optimally manage this area of care for patients.

Interactions between patients and staff were observed throughout the hospital and 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.

5.7 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 demonstrated they were aware of types and indicators of potential abuse and the actions to be taken should a safeguarding issue be identified, including who the nominated safeguarding lead in the hospital was.

Review of the staff training matrix evidenced that all relevant staff had received training in safeguarding children and adults and safeguarding leads had received training at a level appropriate to their role. The patient liaison officer has received safeguarding training as part of induction to the hospital. Their role involves direct contact with patients including parents and children, and upon highlighting this, senior management agreed that this individual would benefit from additional safeguarding training commensurate to the 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.

5.8 Staffing (recruitment and selection, training, supervision and appraisal).

Staffing arrangements were reviewed within the hospital, which confirmed that staff were recruited and employed in accordance with relevant employment legislation and best practice guidance. A random sample of personnel files, which included newly recruited staff, demonstrated that the information required by legislation had been sought and retained through the recruitment and selection process.

A review of duty rotas and discussion with staff evidenced that there were sufficient staff in various roles to fulfil the needs of the hospital and patients. There was a multi-professional team including Consultant Surgeons; Consultant Physicians; Consultant Anaesthetists; Nurses; Radiographers and AHP staff. An RMO was also available on site to provide medical cover and support nursing staff seven days a week, including out of hours cover.

The ward manager confirmed that staff were rostered to meet the needs of patients and a number of bank nurses, who have experience working in the hospital, were available to ensure that adequate staffing levels were maintained. Staffing levels and morale on the wards were good and there was evidence of multidisciplinary working and good communication between staff. Staff told us that they were happy, felt supported and that there were good working relationships throughout the hospital.

Induction programme templates were in place relevant to specific roles within the hospital. A sample of a number of induction programmes confirmed that these had been completed when new staff joined the hospital.

There were monitoring arrangements for mandatory training at ward level and staff confirmed that they have assigned training days. There were opportunities for professional development for nursing staff and one individual had recently completed a leadership course. Discussions with medical staff confirmed they had received mandatory training; and prior to the pandemic there were opportunities to avail of simulation training, which if reintroduced, one clinician felt would promote self-development within this group of staff.

Review of the training matrix evidenced that mandatory training was not up to date in all departments. The ability to access training, in particular face to face training, had been impacted by Covid-19 restrictions. Actions to improve compliance with staff training were ongoing and there were oversight mechanisms in place to monitor progress. The training matrix itself was difficult to interpret and the hospital manager acknowledged this, confirming imminent plans to launch the training matrix on a new information technology platform. Following feedback to the senior management team an updated overview of mandatory training figures for staff was submitted which confirmed good progress with mandatory training. An area for improvement has been identified in relation to ensuring all staff have up to date mandatory training commensurate to their role.

Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place. Staff told us they felt supported and involved in discussions about their personal development. Records evidenced that the majority of ward staff appraisals had been completed on an annual basis, with plans in place to complete the small number of outstanding appraisals. Staff receive regular professional/clinical supervision in line with their professional bodies' guidance/best practice and retain a written record as evidence for inspection purposes. Supervision was generally undertaken as a group but could be requested individually if required.

There was a process in place to review the registration details of all health and social care professionals with their professional bodies. Discussion with the manager and review of documentation evidenced that doctors who deliver services in the hospital provide evidence of 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; and
- ongoing annual appraisal by a trained medical appraiser.

Review of records evidenced that a robust system was in place to review the professional indemnity status of all staff that require individual indemnity cover. Personnel files confirmed that medical practitioners had appropriate professional indemnity insurance in place. A key element in the revalidation process for medical staff is annual appraisal. It was noted a number of doctors annual appraisals had not been completed, however as part of the Department of Health (DOH) Covid-19 response the DOH waived this contractual obligation, consequently, appraisals were suspended until further notice, unless there are exceptional circumstances. Where appraisals had not been completed, due to the impact of Covid-19, this was clearly recorded in the medical practitioner's personnel file and assurance was sought from the senior management team to confirm that arrangements were in place to keep this under review.

5.9 Environment and IPC

Overall the environment and equipment was in a good state of repair, with a high standard of cleaning throughout. The general environment, wards, ICU 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. An identified IPC link champion is available in all departments to provide IPC support and guidance to staff onsite. These champions have undertaken a two day IPC course and can also contact the external IPC advisor for additional guidance if necessary.

Cleaning schedules for both nursing staff and cleaning staff were available and complete. A review of the cleaning schedule for theatres highlighted an inconsistent approach to cleaning in the theatres. Reassuringly, the cleaning schedule in theatres was revised during the inspection to allow for a more consistent approach to cleaning.

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.

5.10 Estates

The management of the environment/building services review was completed remotely. The KPH management team were provided with a checklist of estates related documents to submit to the estates inspector for review. The checklist included maintenance and test certificates relating to the building and engineering services, plus relevant risk assessment documents. All requested documents were submitted, reviewed 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 the AE site visit on 23 February 2022.

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 audit report listed that the building services were in a satisfactory condition and recommended the continuation of ongoing maintenance works. A computerised compliance management system has been introduced to enhance the planned preventative maintenance system required for the building services.

Fire safety precautions records were reviewed during the 12 October 2021 inspection IN039784 process, and currently remain valid.

There were no areas for improvement required as a result of the estates inspector review process.

5.11 Review of patient journey and patient records for cardiac surgical patients, inclusive of staffing arrangements

A review of the patient journey for cardiac surgical procedures from referral, through pre-operative assessment and care, admission, intraoperative care, ICU care, transfer to the ward and then discharge was undertaken. The process was found to be largely aligned with the agreed arrangements for the cardiac surgery care pathway during the ICU registration inspection in October 2021.

It was clearly identified from patient records that a HSC cardiac surgeon made the referral for surgery and the cardiac procedure was identified as one of the five cardiac surgical procedures to be carried out as specified on the registration condition. A detailed pre-admission assessment was undertaken which included reviewing the patients' medical history with the assessment criteria in line with policy and pre-operative investigations. The anaesthetic review was undertaken and surgical consent obtained by the consultant surgeon at the pre-operative admission stage. The cardiac theatre safety checklist was carried out, inclusive of the WHO surgical safety checklist and surgical pause during the intraoperative stage. An appropriately trained ICU nurse was present with the patient during the ICU stage of the process and anaesthetic cover provided while the ICU was operational. There was evidence of ongoing review by the consultant surgeon and anaesthetist while the patient was in the ICU.

During the registration inspection of this service in October 2021, inspectors were concerned that there was limited evidence of the implementation of robust training and competency assessments for staff at ward level in relation to caring for post-operative cardiac surgery patients. Inspectors were provided with assurances that all ward staff would undertake robust training and be assessed in the specific competencies of cardiac advanced life support (CALS) training; drain care and removal; rhythm recognition; pacing and telemetry; and removal of pacing wires. Inspectors were advised that until such times ward staff have successfully completed the training and competency programme, an additional ICU trained nurse will be rostered on the ward.

However, this proved not to be the case for the duration of the patients' hospital stay where following a second readmission to ICU and discharge back to the ward a decision was made to step down ICU nurse cover at ward level in the absence of staff completing the training and competency programme for the care of post cardiac surgical patients. Detailed conversations with senior management team confirmed that whilst a verbal risk assessment was undertaken prior to the decision being made to step down support of an ICU nurse to staff at ward level, there was no documented evidence of a robust risk assessment inclusive of agreement with the ward manager. An area for improvement will be made in this respect.

A review of the patient records outlining the pre, peri and post-operative cardiac surgical care highlighted some concerns relating to the legibility of the clinical notes. Additionally, the notes were not documented in chronological order demonstrating clear continuity of care. This made it difficult to navigate the notes and identify where one staff member finished their entry and where the next staff member would continue. Common throughout the patient notes were illegible entries and staff signatures. This was discussed with the senior management team during the inspection and again at feedback where assurances were given this would be addressed and included within the ongoing documentation audits. An area for improvement will be made in respect of effective record keeping and documentation of medical records.

6.0 Quality Improvement Plan/Areas for Improvement

Three areas for improvement has been identified where action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and the Department of Health (DoH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

	Regulations	Standards
Total number of Areas for Improvement	1	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Sarah Marks, the Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection

Quality Improvement Plan

Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref:** Regulation 18 **Stated:** First time **To be completed by:** 27 May 2022	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. **Ref: 5.8**
	Response by registered person detailing the actions taken: We have procured a new online learning system called Learnpool. This platform allows for staff immediate access, at any time, to all mandatory training to be completed - with the exception of Basic, Intermediate and Paediatric life support which will remain face to face for training. It has an inbuilt audit for monitoring compliance. This platform also contains additional training for staff development . While the implementation is ongoing we expect to be compliant by End June 2022.

Action required to ensure compliance with the Department of Health (DoH) Minimum Care Standards for Independent Healthcare Establishments (July 2014)

Area for improvement 1 **Ref:** Standard 8.2 **Stated:** First time **To be completed by:** 27 May 2022	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. **Ref: 5.11**
	Response by registered person detailing the actions taken: The Cardiac pathway was amended to improve the flow of the patients through the hospital. Additional sections within the notes have been made. This will maintain contemporaneous note taking and clarity to chronology. An audit was completed on the patient notes and presented to the CCQGM. Legibility of hand written notes, signatory completion and chronology of entries were dicussed. This audit findings have been shared with all those staff involved in Cardiac Patient note making and pathway. The new pathway is being printed and will be implemented on reciept
Area for improvement 2 **Ref:** Standard 17 **Stated:** First time **To be completed by:** 27 May 2022	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 assessments, inclusive of agreement with the ward manager. **Ref: 5.11**
	Response by registered person detailing the actions taken: Any variance to patient planned arrangements on transfer from Cardiac Surgical ICU/HDU to ward level care is fully risk assessed by the medical team. This will be documented in the Criteria For Ward Transfer section within the Cardiac Pathway. Any variance is discussed and agreed and this will be signed by both the Consutlant Surgeon and the accepting Ward Manager. This is now complete

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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care