Inspection Report

22 and 23 January 2025

Kingsbridge Private Hospital

Type of service: Independent Hospital
Address: 811-815 Lisburn Road, Belfast, BT9 7GX
Telephone number: 028 9066 7878

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

1.0 Service information

Organisation/Registered Provider: Kingsbridge Healthcare Group Limited **Responsible Individual:** Mr Mark Regan	**Registered Manager:** Ms Kelly Macartney **Date registered:** 13 September 2022
Person in charge at the time of inspection: Kelly Macartney	**Number of registered places:** 36 Inpatient beds (inclusive of two critical care beds) 12 Day surgery beds
Categories of care: Independent Hospital (IH) Acute Hospital Inpatient (AH) Acute Hospital Day surgery (AH(DS)) Private Doctors (PD) Prescribed Technologies (PT) Endoscopy PT(E)	
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 36 patients as in-patients and 12 day surgery beds. The hospital has four 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 also offers cardiac surgery procedures and has two critical care beds for the provision of post-cardiac surgery critical care as required. Kingsbridge Healthcare Group Limited is the registered provider for three independent hospitals registered with RQIA. Mr Mark Regan is the responsible individual for Kingsbridge Healthcare Group Limited.	

2.0 Inspection summary

A short notice announced inspection was undertaken to the KPH on 22 and 23 January 2025 and included a request for the submission of information electronically.

The onsite care component of the inspection was undertaken by two senior inspectors, four care inspectors and an ADEPT (Achieve Develop Explore Programme for Trainees) Fellow on 22 and 23 January 2025.

The ADEPT fellowship provides senior doctors in training with an opportunity to take time off their medical training for one year and work in an apprenticeship model with senior leaders in host organisations across Northern Ireland in order to develop organisation and leadership skills.

The electronic submission of additional documentation in relation to the premises aspect of the inspection was reviewed remotely by an RQIA estates inspector and feedback was provided to the registered person following the inspection.

This inspection focused on five main key themes: organisational and clinical governance; staffing arrangements; the management of cardiac surgery patients' care pathway; the management of the general surgery patients' care pathway and estates management.

Examples of good practice were evidenced in patient safety in respect of the management of the patients' care pathway and engagement to enhance the patients' experience.

One area for improvement has been identified against the standards to appoint an external independent organisation or human resource advisor to undertake a cultural assessment of the hospital. An action plan should be generated to address any recommendations within the report detailing the main findings of the cultural assessment.

Feedback of the inspection findings was delivered to the KPH management upon conclusion of the inspection.

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

3.0 How we inspect

RQIA is required to inspect registered services in accordance with legislation. To do this, we gather and review the information we hold about the service, examine a variety of relevant records, meet and talk with staff and management and observe practices on the days of the inspection.

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

- notifiable events since the previous care inspection
- the registration status of the hospital
- written and verbal communication received since the previous care inspection

- the previous care inspection report.

The inspection team undertook a tour of the premises and the inspection was facilitated by Ms Macartney and other staff members.

The inspection team spoke with; Mr Regan; Ms Macartney; the medical director; the theatre manager; the senior theatre sister; theatre nursing staff; Post Anaesthesia Care Unit (PACU) manager, a consultant cardiac surgeon, a consultant cardiac anaesthetist, the residential medical officer; the inpatient unit ward sister, two inpatient unit deputy sisters; a ward based staff nurse caring for post-operative cardiac patients, the Infection Prevention and Control(IPC) lead nurse and members of the hospital liaison team.

The information obtained is then considered before a determination is made on whether the establishment is operating in accordance with the relevant legislation and minimum standards.

Examples of good practice are acknowledged and any areas for improvement are discussed with the person in charge and detailed in the QIP.

4.0 What people told us about the service

Posters were issued to KPH by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire.

Two patient and one relative/visitor submitted responses. The three respondents indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led. All patients indicated that they were very satisfied with each of these areas of their care. The three respondents included comments stating they found staff to be very helpful and that they had received excellent care and treatment.

Two post-operative cardiac patients and two of their relatives spoken with described having a very positive experience of the cardiac surgical services. They confirmed that staff were very professional, attentive and their pain was well managed. They were kept well informed at each step of the patient journey. Relatives advised that overall the interpreting service provided was in accordance to the patient's communication needs, however the precise language required should be always be confirmed. Management were receptive to the comment and agreed to follow up.

22 staff submitted questionnaire responses. A review of the questionnaire responses revealed a mixed response from staff when asked if they found the care provided was safe, effective and if patients were treated with compassion. 13 respondents indicated they were satisfied in this regard. The remaining staff stated they were either undecided, dissatisfied or very dissatisfied. When asked if they found the service to be well led, two staff members indicated they were satisfied in this regard, six staff were undecided and the remaining staff were either dissatisfied or very dissatisfied.

21 of the staff respondents included additional comments which required further discussion with KPH. As a result of the concerns raised by staff who completed the questionnaires a Microsoft Teams meeting was arranged between KPH and RQIA. Information was provided to KPH on the concerns raised by staff members.

Based on staff feedback and additional comments provided to RQIA, an area for improvement has been made against the standards that an external independent organisation or human resource advisor should be appointed to undertake a cultural assessment of the hospital. An action plan should be generated to address any recommendations within the report detailing the main findings of the cultural assessment.

RQIA also advised KPH management, that in the interim, they should follow up on the issues staff had shared with RQIA as a matter of priority. Assurances were provided by KPH management in this regard.

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 15 May 2023; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Governance and Leadership

Organisational Governance

Various aspects of the organisational and medical governance systems were reviewed and evidenced a clear organisational structure within KPH.

As previously outlined, Mr Regan is the responsible individual and Ms Macartney is the registered manager with overall responsibility for the day to day management of KPH.

KPH is part of the Kingsbridge Healthcare Group (KHG) and is supported by well-established governance arrangements. The Quality Improvement Strategy 2025 is in place which outlines five strands of improvement for the Kingsbridge Healthcare Group. A review of the Governance and Compliance Strategy and Framework demonstrated that the KHG has developed a robust governance model that involves a network of quality teams operating through all levels and disciplines within the organisation. These teams allow for communication throughout the organisation ensuring a steady flow of information.

Each hospital has a local management team (LMT) who meet weekly with departmental heads to report and discuss on clinical governance and compliance issues such as complaints, incidents and learning outcomes with action plans and timeframes.

The local governance and quality team (LGQT) meet monthly to discuss and work through their local quality agenda. Standing core agenda items include risk management and clinical effectiveness including incidents and complaints, audit, policy updates/ratification, appraisals, training and continuous professional development (CPD), patient and staff experience and quality management systems.

The LGQT will create action plans and will report to and seek advice from the Medical Advisory Committee (MAC) as required. This is discussed further within the next section of this report.

The LGQT provides upward and downward assurance within the KHG for the clinical governance and the quality agenda. Attendees at the meeting are required to ensure appropriate cascade of information to staff groups. Minutes and action plans are circulated to members to facilitate discussion at local management and team meeting level.

A monthly intensive care unit (ICU) governance and quality team meeting takes place and mirrors the LGQT meeting in terms of the meeting agenda items. The attendees include the ICU lead, members of the surgical and consultant anaesthetic body, the recovery/ICU manager, the nurse clinical lead, the clinical education nurse and the clinical equipment lead. The cardiac theatre coordinator, the lead perfusionist and the lead cardiac ward nurse may also be required to attend. Any issues from this group will be escalated directly to the medical advisory committee (MAC) as appropriate.

A quarterly group administrative governance and quality team meeting also takes place. Attendees are representative departmental managers or leads from all areas of the KHG. The agenda for the group focuses on governance, quality key performance indicators (KPIs) and risk management and education. The rolling agenda includes updates from every departmental manager regarding any group learning outcomes from complaints, incidents, trend analysis, audit findings, operational issues and business development issues. This group produces a quarterly and annual quality report to the Board.

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

The Competition and Markets Authority (CMA) requires that all hospitals and consultants offering private treatment submit data to the Private Healthcare Information Network (PHIN) as the Information Organisation for private healthcare. This provides people considering private healthcare with clear information to help them make an informed choice of which consultant and hospital is right for them.

We were informed that an electronic system for receiving patient experience feedback has been implemented which enables the KPH to feed into PHIN. There was also evidence of patient feedback being shared with staff as a means of continually evaluating and driving service improvement.

A range of policies and procedures were accessible and evidenced. 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.

Discussion with staff and a review of records evidenced that staff meetings take place every month and minutes were available to review.

Clinical and medical governance

Over 300 consultant specialists work in the hospital.

The KHG Board of Directors (the Board) requires consultant medical practitioners to practice in accordance with the General Medical Council (GMC) guidance 'Good Medical Practice', completing appropriate appraisal and revalidation requirements and adhering to the KHG's practising privileges agreement.

As previously outlined, LGQT meet on a monthly basis and assist the Board in its oversight and integrity of KPH's clinical governance arrangements, including responsibilities regarding RQIA and the PHIN. The duties of the LGQT include ensuring there is a robust mechanism for reporting and recording of all clinical incidents and to regularly review all such incidents; consider issues of concern relating to the clinical practice of an individual, where identified, and bring to the attention of the MAC; review and monitor all complaints relating to clinical issues; to have oversight and monitor the risk management system and controls in place and escalate any major risks identified to the Board; to ensure the MAC is in receipt of all consultants practising privileges documentation; to have oversight of the duties and responsibilities of the Resident Medical Officers and monitor their performance on a regular basis. In conjunction with the MAC, the LGQT will identify areas appropriate for medical audit and will oversee these audits and outcomes.

Audits recently undertaken included; inpatient falls audit; patient complaints audit; antimicrobial prophylaxis prescribing audit for cardiac surgery patients; breast surgery surgical site infection audit; as well as quarterly infection prevention and control audits.

In addition to the above, a number of management reports providing an overview of the cardiac, orthopaedic and adenotonsillectomy procedures completed at KPH had been completed and were available for review by inspectors. It was confirmed that audit findings, including IPC audit findings, are shared at the LMT and LGQT meetings and at the IPC steering group meetings.

The MAC meets quarterly with responsibility for surgeon performance and surgery specific matters. As discussed, the LGQT ensures that all the documentation for consultants with practising privileges are in place including checking registration with the GMC, professional indemnity and appraisals. Terms of reference for the MAC were in place and these have been developed in accordance with Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments (2014). It was evidenced that the MAC meetings have standing agenda items and are used as a forum to discuss: clinical governance issues, the appointment and renewal of practising privileges agreements, the review of performance indicators, corrective action in relation to adverse clinical incidents and any other untoward event or near miss. A review of MAC meeting minutes confirmed that these meetings were being undertaken on a quarterly basis in line with the criteria set out in Standard 30.

In accordance with the requirements of registration with the GMC, all doctors must revalidate every five years. The revalidation process requires doctors to collect examples of their work to understand what they are doing well and how they can improve.

Experienced senior doctors work as Responsible Officers (ROs) with the GMC to make sure doctors are reviewing their work. As part of the revalidation process, ROs make a revalidation recommendation to the GMC. It was established that KHG is registered with the GMC as a designated body and have an appointed RO.

A number of consultants are considered to be wholly private doctors as they are not affiliated with the Health and Social Care (HSC) sector in Northern Ireland (NI) and are not on the Northern Ireland Primary Medical Performers List (PMPL). A review of a sample of three consultants' details confirmed evidence of the following:

- confirmation of identity
- current GMC registration
- professional indemnity insurance
- qualifications in line with service provided
- ongoing professional development and continued medical education that meets the requirements of the Royal Colleges and the GMC
- ongoing annual appraisal by a trained Medical Appraiser
- an appointed RO
- arrangements for revalidation

Appraisal is a key part of revalidation and includes the appraisee providing evidence of their individual continuing professional development (CPD) activities undertaken in accordance with the GMC Good Medical Practice. It was demonstrated that systems have been strengthened to ensure they have an accurate and up to date position on medical appraisal status which clearly evidences any delay. A system was in place to record when appraisals have been received. If there has been a delay reason, the date the appraisal is expected to be submitted is documented.

We reviewed the arrangements for the oversight and recording of induction and on-going training for consultants to ensure all consultants working in KPH receive mandatory training and other training, supervision and appraisal in accordance with best practice guidance.

Since the previous RQIA inspection it was good to see that a fresh approach has been taken to ensure all consultants complete KHG's mandatory training requirements and this begins at the point of a consultant making application to work in KPH. A review of training records demonstrated that progress is being made in this regard. As previously discussed, training compliance rates are included in the quarterly LGQT and MAC meetings.

Practising Privileges

The only mechanism for a medical practitioner to work in a registered independent hospital is, either under a practising privileges agreement or, through direct employment by the hospital.

It was established that the majority of consultants who work in KPH are not directly employed and work under a practising privileges agreement.

A detailed policy and procedural guidance for the granting, review and withdrawal of practicing privileges agreements was in place. It was evidenced that this policy states that practising privileges can only be granted or renewed when full and satisfactory information has been sought and retained in respect of each of the records specified in Regulation 19 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended.

As previously discussed, a review of the practising privileges agreement confirmed that there is clear and accurate information on when annual appraisals should be submitted and clear escalation actions are outlined if annual appraisals are not submitted within the specified time.

It was also demonstrated that the practising privileges application now includes a requirement to demonstrate completion of specific areas of mandatory training and also ongoing registration with the Information Commissioner's Office (ICO). A practising privileges portal is being rolled out to enable medical practitioners to submit the required documentation electronically. This electronic system will also have the facility to issue reminders and other communications to medical practitioners.

It was demonstrated that practising privileges matters are discussed and reviewed during the MAC meetings.

Good oversight arrangements of the granting of practicing privileges agreements were in place and provided assurance of robust medical governance arrangements within the organisation.

Quality assurance

Arrangements were in place to monitor, audit and review the effectiveness and quality of care and treatment delivered to patients at appropriate intervals.

Significant incidents and themes reported are discussed during the LMT, LGCT and MAC meetings.

There was a robust programme for internal audit to monitor compliance with policies and processes. Audits are completed monthly, quarterly and annually as per the KHG's audit schedule. As previously discussed the outcomes are monitored by the LGQT and actions identified for improvement are embedded into practice. If required, an action plan is developed to address any shortfalls identified during the audit process.

It was demonstrated that 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.

Notifiable Events/Incidents

The previously discussed Governance and Compliance Strategy and Framework provides an overview of the mechanisms in place, roles and responsibilities at all levels throughout KPH, to oversee, report and respond to clinical risks, incidents and near misses. This includes reporting requirements to external bodies as required and arrangements for the management of national safety alerts. A Group Adverse Incident policy further describes the internal electronic reporting mechanism, which is accessible to all staff, and corresponding investigation pathways following categorisation of the incident.

Review of meeting minutes and discussion with the management team confirmed that any learning from incidents would be cascaded to relevant staff members.
There was a process in place for analysing incidents and events to detect potential or actual trends or weakness in a particular area in order that a prompt and effective response can be considered at the earliest opportunity.

As previously mentioned significant incidents and themes reported are discussed at the organisation's clinical governance meetings, the MAC and health and safety committees.

Complaints Management

A copy of the KPH complaints policy was available for review and was found to be in line with relevant legislation and Department of Health (DoH) guidance on complaints handling.

Discussion with staff confirmed that a copy of the complaints procedure is made available for patients and/or their representatives on request and staff demonstrated a good awareness of complaints management.

Review of the complaints log confirmed that all complaints received in the previous 12 months were investigated and responded to in line with the complaints policy. Details of all communications with complainants; any investigation undertaken and the resultant actions were documented. Any learning from the investigation of complaints is disseminated across all staff groups to drive improvement in the quality of the service.

A recent complaints audit completed was available for review during the inspection. The audit was up to date and capable of reflecting any themes emerging from complaints analysis.

The KPH management team described an effective governance structure that provides a process and system of accountability to support the delivery of good quality service and to monitor and maintain high standards of care.

5.2.2 Does the hospital have appropriately qualified and skilled staff in place?

The arrangements for the recruitment and selection of staff were reviewed. A recruitment policy and procedure was in place in keeping with legislation and best practice guidance.

The KHG training academy provides an ongoing training programme. All staff are facilitated and encouraged to take part in ongoing training to update their knowledge and skills, relevant to their role. The training academy provides Ms Macartney with a monthly update of completed staff training.

An electronic system was in place to monitor all aspects of ongoing professional development and a record was retained of all training and professional development activities. A review of the electronic system confirmed a high level of compliance. Staff had either completed or were in the process of completing training as outlined in the RQIA training guidance and legislation.

Induction programmes relevant to roles and responsibilities are required to be completed when new staff join the team. A review of records confirmed that the newly appointed authorised operators had completed a programme of induction.
Discussion with Ms Macartney, in conjunction with a review of documentation, confirmed that robust arrangements were in place to check the registration status for all clinical staff on appointment and twice yearly on an ongoing basis. The arrangement for monitoring the professional indemnity of all staff was also in place.

It was determined that appropriate staffing levels were in place to meet the needs of patients and the staff were suitable trained to carry out their duties.

Cardiac surgery

It was confirmed that KPH has appointed a clinical nurse educator who is an experienced cardiac ICU nurse. The clinical nurse educator is responsible for the development and implementation of an education programme for all disciplines of staff involved in the post – operative care of cardiac patients.

It was confirmed that validated competency and assessment tools such as ICU Critical Care Network Northern Ireland (CCaNNI) tools and cardiac tools have been used to devise competency assessments for staff in ICU. It was confirmed that all KPH ICU nurses have undertaken a validated cardiology course.

The ICU staff received induction training and orientation to the ICU facility. ICU staff have undertaken cardiac advanced life support (CALS), intermediate life support (ILS) and advanced life support (ALS) training and completed all mandatory training.

It was confirmed that a training and competency framework for nurses at ward level in relation to caring for post-operative cardiac surgery patients was in place. It had been completed by a number of nurses at ward level to ensure there are appropriately trained and competent nurses to care for post-operative cardiac surgery patients during their recovery at ward level.

Consultant medical staff have declared competency in providing specialised cardiac surgery through a detailed competency framework which forms part of a review of qualifications and experience before they are granted practising privileges by the chair of the medical advisory committee (MAC).

Following discussion with a resident medical officer (RMO) and review of documentation, it was confirmed that the training and assessment of competency of RMOs to provide medical care to post-operative cardiac patients at ward level, was limited. A 'Resident Medical Officer Competency Self-Assessment –Cardiac surgery post-operative ward care framework' had previously been in place. However, it was identified that this has not been implemented for the current RMOs in place. The matter was fully discussed with management who recognised the need to provide formal training and learning opportunities for RMOs in relation to cardiac surgery post-operative ward based care.

Following the inspection, RQIA was provided with written confirmation that a RMO training and competency workshop has been arranged for 13 and 19 February 2025. A learning achievement document has been devised which will be held for each RMO in their personnel file. It was confirmed that all RMOs working in KPH Belfast will attend this mandatory training. It was also confirmed that the lead cardiac surgeon will be on site fortnightly to provide additional bespoke training for those who require it.

All RMOs working while a cardiac patient is an inpatient, will formulate part of the ICU and ward round each morning and gain access to additional training/experience from the Cardiac surgeons and Anaesthetists. The medical director and lead cardiac surgeon have agreed that the self-assessment document is no longer required. Instead, all RMO staff will attend the workshop to act as either revision or new learning and a record will be held.

The cardiac theatre nursing staff training and competencies for anaesthetic and scrub nurse roles was reviewed.

It was confirmed that long term bank theatre nurses with experience in cardiac surgery who are also working in HSC cardiac theatres continue to assist in the cardiac surgery in KPH. It was confirmed KPH theatre nurses are also present. The upskilling of the KPH theatre nurse's role for cardiac surgery was discussed and confirmed as still under development. Following inspection, a cardiac theatre competency booklet was submitted to RQIA stating that staff have been actively completing this document as their competency grows. It was noted to be a HSC document. It was confirmed that it had been added to KPH group document review for updating. This review will also further expand the core competencies for anaesthetics nurse's role in cardiac surgery. It is hoped this will provide robust development opportunities for KPH theatre nurses.

As a result of the actions taken following the inspection, it is determined that appropriate staffing levels are in place to meet the needs of patients and the staff were suitably trained to carry out their duties.

5.2.3 Are there safe practices in place for the day surgery and inpatient services?

The inspectors reviewed the arrangements for the provision of day surgery and inpatient services as outlined in the statement of purpose and categories of care.

The inpatient unit is divided into five wards and a day procedure unit.

During a tour of some areas of the inpatient wards and the day procedure unit, it was observed that the clinical and decontamination areas were clean, tidy and uncluttered.

There were hand hygiene facilities available throughout the unit. All areas of the inpatient units observed were equipped to meet the needs of patients.

The surgical pathway 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.

A sample of patient care records were reviewed and confirmed that they included a contemporaneous note of each patient's medical history, medicine regime and treatment provided. However, it was identified that some patient care records were incomplete. The identified records were discussed with Ms Macartney and assurances were received that these matters would be reviewed.

A review of patient assessments such as National Early Warning Score (NEWS) charts confirmed that they were well completed and scores actioned if necessary.
Nursing staff demonstrated a good knowledge of assessment and ongoing review of pain management. Pain management records were maintained to a satisfactory standard.
Staff described excellent links with the multi-disciplinary team (MDT) to optimally manage this area of care for patients.

As a result of the actions taken and the assurances provided by Ms Macartney, it was determined that safe practices were in place for the inpatient services.

5.2.4 How does the service ensure that cardiac and other surgical services are safe?

Cardiac Surgical Pathway

The arrangements for the provision of cardiac surgery services were reviewed. Staffing arrangements for the provision of the cardiac surgery service in KPH were examined across all staff disciplines. It was confirmed that a multidisciplinary team comprising of:

- one ICU lead doctor- consultant anaesthetist
- three ICU consultant anaesthetists
- six cardiac surgeons
- PACU manager
- a team of ICU trained nurses
- clinical equipment technicians
- theatre staff experienced in cardiac surgery
- perfusionists
- ward nursing staff
- resident medical officer (ward level)
- radiographers on call
- physiotherapist with respiratory experience
- allied health professionals (as required)
- clinical nurse educator (providing an education programme to staff)
- IPC lead nurse (consultation)
- clinical microbiologist
- senior pharmacist and supporting pharmacists.

The cardiac surgery patient journey was examined, through discussion with key medical and nursing staff, review of the facilities, scrutiny of relevant policies/ procedures and care pathway documentation.

It was confirmed that there will be a clear selection criterion in place for KPH cardiac surgery patients. With the absolute exclusion criteria of patients under 18 years of age, weight must not be greater than 155kg and patient must not be pregnant. The selection criteria have a list of clinical conditions as contraindications for selection which are set out in a KPH Intensive Care Unit Criteria for Case Selection policy.

Referrals

Referrals for cardiac surgery will be through a HSC cardiac surgeon and the patient will have an already identified need for a specific cardiac surgical procedure. They may be self-funding patients or patients with health insurance cover.

Pre-admission

A detailed pre-admission assessment of the patient will be carried out jointly by a cardiac surgeon and a consultant cardiac anaesthetist. The case will then be presented at the weekly ICU governance meeting for consideration by the MDT. Taking into account the KPH selection criteria and the patient's fitness for surgery, a decision will be made if the patient is suitable for cardiac surgery in KPH.

Pre –operative assessment

If deemed suitable, they will have an extensive pre-operative assessment and work up to ensure they are suitable for the KPH enhanced cardiac surgery -cardiothoracic surgery care pathway protocol.

At the outpatient consultation, the patient will receive an information booklet which includes information to help decision making and consent while waiting for cardiac surgery. The following is part of the pre-operative assessment (POA) arrangements: -

- POA two weeks prior to operation date
- the appropriate pre-operative assessment pathway is used
- during POA, prescription made out in advance for albumin
- date of operation to be confirmed
- date for outpatients for repeat group and screening, full blood count, international normalised ratio (INR), urea and electrolytes.

Scheduling Theatre/ Pre-operative care following admission

The lead cardiac surgeon in KPH confirms the schedule and the theatre list with the involvement of the consultant cardiac surgeon, consultant cardiac anaesthetist, theatre manager and PACU manager.

The following is the care pathway for the patient on admission: -

- the patient will be admitted either the night before or on the day of surgery to ensure that all markers are stable, and the patient is fit for theatre. A pre-operative assessment will be completed. The cardiac surgery care pathway, which is a MDT care pathway covering the patients journey from admission to discharge, will be commenced.
- the patient will be seen by the consultant anaesthetist and anaesthetic assessment is completed within the cardiac pathway.
- the consultant anaesthetist will order four units of packed red cells for delivery to the KPH that evening.
- the patient will have bloods taken for full blood count (FBC) / urea & electrolytes (U&E), group and cross match.
- the patient will be seen by the surgeon who will confirm there is no clinical change in the patient, consent obtained and any further questions answered.
- ward medicine Kardex will be commenced by RMO in relation to routine medications.
- the anaesthetist will advise regarding night sedation and any routine medications to be omitted.
- the cardiac surgeon will complete the thrombus/bleeding risk and will confirm any anti-coagulation therapy required with the RMO.
- the patient will be advised to fast from food and fluids as per KPH protocol.

Intra –operative care

The patient is accompanied to theatre by a ward nurse. If sedative pre-medication has been prescribed, this will be administered in the bed. Theatre 4 has been identified for cardiac surgery as it is adjacent to the ICU facility. An anaesthetic nurse will meet the patient at theatre door and will carry out a detailed checklist.

The patient will be taken into theatre where pre-operative health and safety equipment checks will be completed and recorded.

A detailed cardiac theatre safety checklist will be carried out, this includes the World Health Organisation surgical safety checklist and surgical pause. This will be recorded in the theatre section of cardiac surgery care pathway documentation. The operation will be carried out and the patient will be monitored throughout. The intra-operative documentation will be completed including a comprehensive anaesthetic record; details of skin prep; pacing wires used; chest wound drainage systems inserted; specimens sent to the laboratory; cardiac theatres check form (swabs; disposables; sutures/needles); cardiac theatre sterilisation details; cardiac theatre implant details; central venous catheter (CVC) checklist; fluid balance; critical care unit (CCU) medicine Kardex and a blood transfusion record, if required.

Two perfusionists are on site, one in the theatre with the patient and one in the theatre suite with a back-up bypass machine in a state of readiness should it be required.

The surgical register is completed. The operation notes are completed by the cardiac surgeon.

ICU care

Following the successful conclusion of surgery, the ventilated patient is admitted to the ICU where the patient commences the ICU component of the cardiac surgery care pathway. A full handover is given from theatre team to the ICU team. The ventilator settings and position is checked as per clinical technician set up. Staff ensure that a peripheral line observation is in place and that all lines are labelled. They will ensure all lines; catheter; pacing wires; drains; delirium score is documented in the comprehensive ICU observation chart. The patient will be cared for on a 1:1 ratio by a trained ICU nurse. Nurse handovers will take place throughout the patients stay in ICU/ High dependency Unit (HDU) and ward level at 7.45am and 7.45pm daily at the change of shift or when handing over for staff rest breaks.

While the patient is in ICU the medical cover will include the following: -

- the operating team are on the premises for at least one hour after the last case is admitted to ICU. They confirm with person in charge in ICU before they leave the premises.
- there is a live-in consultant anaesthetist 24 hours a day until the patient returns to the ward.
- there is an on call cardiac surgeon and surgical team.
- a consultant surgeon reviews the patient daily.
- a consultant anaesthetist carries out twice daily ward rounds morning and evening whilst patient is in ICU/HDU.
- a daily MDT ward round is carried out.

The usual recovery involves that on day one post–operatively the patient is extubated and the HDU section of the cardiac surgery care pathway is commenced.

Transfer from ICU to ward level

On day two the transfer to ward checklist is commenced. If a patient meets the KPH discharge criteria from ICU to the ward the patient is transferred to ward level.

The decision to transfer to the ward is made by the consultant anaesthetist and the cardiac surgeon. Patients are only transferred to the ward between the hours of 8:00am and 6:00pm.

An appropriately trained and skilled ward nurse joins the ICU team in the ICU department the morning the patient is planned for transfer to the ward to facilitate continuity of care and effective transfer for the patient from ICU to ward level. The ward nurse transfers with the patient to ward level and continues to care for the patient. The patient is located in a single bedroom which is spacious enough to accommodate a range of clinical equipment. The patients' rooms are located on the same floor as ICU and the cardiac theatre 4. The ward level section of the cardiac surgery care pathway is commenced. The patient remains on monitoring for 48 hours post discharge to the ward via telemetry link to the nursing station. There is MDT approach to care with physiotherapy daily input if required.

It was confirmed the medical cover at ward level is a RMO providing 24 hour live-in cover with the remote support of the consultant cardiac surgeon and consultant anaesthetist. The lead cardiac surgeon is on site during the day whilst the cardiac post-operative patients are recovering at ward level. It was confirmed that the consultant surgeon and consultant anaesthetist are contactable by phone and available to attend within 30 minutes following ICU/HDU discharge.

The consultant surgeon conducts a daily ward round with the nursing team looking after the patient on the ward. During this ward round the management decisions on the patient's continuity of care are taken and documented in the cardiac surgery care pathway accordingly.

A consultant-to-consultant handover takes place should there be a change in the consultant in charge of the patient.

Discharge from KPH

There are clear discharge procedures in place and the patient is deemed fit for discharge by the consultant cardiac surgeon. The discharge section of the cardiac surgery care pathway is completed by the nursing staff and the RMO. This includes arrangements for providing the patient with written discharge information and education booklets; referral to the Health Education and Rehabilitation Therapy (HEART) team; GP letter; district nurse letter; drug information list; medication; warfarin booklet; patients own medication; outpatients review planned and details of how to contact the ward for advice or if concerned.

If required a referral may be appropriate to the psychotherapy and counselling service. A decision to make this referral will be made by the consultant cardiac surgeon in conjunction with the members of the MDT responsible for the patients' post-operative care.

It was confirmed that following discharge patients receive at least two follow up calls from suitably trained and deemed competent nursing staff who will conduct the calls in line with an agreed script which will be fully documented. Any concerns will be escalated to the RMO in the first instance who may then contact the consultant cardiac surgeon.

Post-operative cardiac surgery patients who do not follow the expected patient pathway.

It was confirmed that, if a patient in ICU is not deemed fit to transfer to the ward and continue to require to be cared for in ICU, adequately trained staff are in place to continue to support that patient.

This type of patient may need additional time to recover and are successfully discharged to the ward following a period longer in the HDU. The patient's ongoing plan of care will be discussed and recorded by the consultant anaesthetist and consultant cardiac surgeon. This was the case during the inspection when a patient remained in ICU until deemed fit for transfer.

For patients whose condition may deteriorate, the decision to return a patient to theatre or to the ICU is made by the consultant surgical team (operating consultant anaesthetist and consultant cardiac surgeon). The anaesthetist leads on these decisions whilst the patient is in the ICU/HDU and the surgeon leads once the patient has been discharged to the ward. The RMO takes part in the day to day management of the patient whilst they are on the ward under the direction of the consultant surgeon and consultant anaesthetist. There is an on call surgical team who can be in the hospital within 30 minutes.

Whilst patients selected for cardiac surgery in KPH are viewed as lower risk group, however, given the nature of the cardiac surgical programme, it is understood that a small number of patients may experience surgical complications. These patients may deteriorate quickly and on occasions require advanced therapies such as renal replacement therapy; advanced interventions relating to airway management; ventilation and cardiac assistance such as ventricular assist devices. It was noted KPH have a list of the triggers for transfer within the cardiac trigger to transfer to HSC from ICU post-operative policy.

The KPH transfer policy was in place and it outlined detailed information on post-operative patient transfer by KPH.

It was confirmed that KPH have arrangements in place for the support of Northern Ireland specialist transfer and retrieval (NISTAR) team when transferring a critically ill patient.

It was confirmed a memorandum of understanding (MOU) between the Belfast Health and Social Care Trust (BHSCT) and KPH for the transfer of critically ill post-operative cardiac patients from KPH to a HSC ICU has been established and is subject to review as agreed.

General Surgical Services

The arrangements for the provision of other surgery services in the hospital as outlined in the statement of purpose and categories of care were reviewed. The inspection team evidenced that these services operate in accordance with best practice and national standards to ensure care delivery is safe and effective.

It was confirmed that adult and limited paediatric surgical services are provided. The scheduling of patients for surgical procedures is co-ordinated by the booking office, senior management and the theatre manager. 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, and any associated risks.

The patient will be sent information about the procedure and any preparation necessary in advance, together with the consent form. The consent process is completed by the consultant carrying out the procedure as part of the admission process.

Staff confirmed that there will be an identified member of nursing staff, with relevant experience, in charge during all surgical procedures which is formally recorded. Staff complete a surgical safety checklist based on World Health Organisation (WHO) guidance and completion of the surgical checklist and compliance is routinely audited through the hospital's auditing process.

It was confirmed that patients are observed during and after the surgery procedures by appropriately trained staff. Surgery patients are transferred to the ward area in accordance with recovery area discharge criteria by the nursing staff. It was confirmed that if there were any concerns about the patient's condition, the consultant would be immediately informed for ongoing management.

A surgical register for each theatre was in place and they were found to be well recorded in accordance with regulation. It was confirmed surgical assistants are used in the hospital. A written log and an electronic log is maintained to confirm they have been granted practising privileges with a defined scope of practice for their participation in specific surgery. However, it was noted that this did not include the details of all the surgical assistants who were noted to have participated in surgery as outlined on the surgical registers. Following inspection, it was confirmed that the theatre staff now have access to a fully digital surgical assistant register which is accessed through SharePoint. This allows staff to have the most up to date information of who has been granted practising privileges to act as a surgical assistant. The hard copy written information has been now removed.

The surgical assistants have practising privileges with the hospital and operate within a defined scope of practice. This is further discussed in section 5.2.1 of this report.

Kingsbridge Private Hospital North West (KPHNW) has an EN ISO 13485 certified Hospital Sterilisation and Decontamination Unit (HSDU) on site. This HSDU supplies sterile instrument packs for surgical procedures in KPH Belfast. There are robust measures in place to monitor the traceability of all surgical instruments used in the hospital.

Clinical equipment was evidenced to be clean and fit for purpose, and traceability labels were used to identify when equipment had been cleaned.

A wide range of comprehensive policies and procedures were in place to ensure that safe and effective care is provided to patients in accordance with good practice guidelines and national standards.

There were procedures for the collection, labelling, storage, preservation, transport and administration of specimens. Staff clearly described these procedures and the procedure for reporting results to the appropriate clinical staff and GPs. It was confirmed there is a contract in place with a pathology laboratory service. The pathology services are subject to internal audit.

An emergency trolley containing emergency medicines and equipment is readily accessible to each of the inpatient wards. Each trolley is checked daily by nursing staff. Emergency medicines were stored securely and oxygen was noted to be in date. There were separate adult and paediatric emergency medicines and equipment in place. A review of the emergency trolleys identified that some items were required to be replaced. This was discussed with the nursing staff who gave assurances that these matters would be addressed.

A review of the emergency trolley checklists identified that there were gaps in the records for two of the emergency trolley checks. This was discussed with the ward manager who confirmed that this issue had already been identified by staff and provided assurances that systems were in place to address this matter.

Medical emergencies were discussed including the management of a massive blood loss emergency. Theatre management confirmed massive blood loss drills have taken place and that an update is to be arranged in the near future. There was a separate massive blood loss tray and relevant documentation folder in place.

Theatre management confirmed that joint replacement information is provided for the National Joint Registry (NJR) with the consent of patients. The hospital similarly also participates in 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. Review of completed documentation in relation to NJR and BCIR noted they were overall well completed. However, the sign off by the consultant surgeon as outlined in the hospital's policy and procedure on NJR and BCIR was not evidenced. Following the inspection, it was confirmed that the forms had been updated to provide an area for the consultant to sign where they have delegated the completion duty to a member of the nursing staff. Consultants are aware it is their responsibility to complete these documents. This signature acts as confirmation they have checked the data completeness.

Patients are 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.

It was determined that safe practices were in place for delivery of cardiac and other surgery services.

5.2.5 Estates

The following documentation in relation to the maintenance of the premises including mechanical and electrical services was reviewed. Discussion with KPH Estates Manager and various estates staff demonstrated that suitable arrangements are in place for maintaining the environment in accordance with current legislation and best practice guidance. The following documents were reviewed:

- the Fire Risk Assessment
- service records for the premises fire alarm and detection system
- service records for the premises emergency lighting installation
- service records for the premises portable fire-fighting equipment
- records relating to the required weekly and monthly fire safety function checks
- records of fire drills undertaken
- Lifting Operations and Lifting Equipment Regulations (LOLER) 'Thorough Examination' reports of the premises' lifts and patient lifting equipment
- condition report for the premises' fixed wiring installation
- condition report for the formal testing of the premises' portable electrical appliances;
- the Legionella Risk Assessment
- service records and validation checks for the premises specialist ventilation systems, medical gases pipeline services and decontamination; and
- service records for the premises space heating boilers and emergency standby electrical generator

The premises' specialised ventilation systems and medical gas pipeline services, continue to be serviced and maintained in accordance with current best practice guidance. Suitable validation is undertaken in accordance with the current Health Technical Memoranda. Records and validation reports were available and reviewed at the time of the inspection.

A current legionella risk assessment was in place and suitable control measures for the premises hot and cold water systems were being undertaken with appropriate records being maintained. We established that a full chemical treatment of the premises' hot and cold water systems is undertaken annually. Regular bacteriological sampling of the hot and cold water systems is also regularly undertaken and appropriate action is taken when necessary.

The fire risk assessment continues to be reviewed by a suitably accredited fire risk assessor. Overall assessment of the risk assessment was assessed as 'tolerable' and the significant findings had been suitably addressed. Through discussion with staff we confirmed suitable fire safety training was being delivered and staff demonstrated that they were aware of the action to be taken in the event of a fire.

It was determined that procedures are in place for maintaining the premise, grounds, engineering services and equipment in line with legislation, current standards of best practice and manufacturer's and supplier's guidance and that these are regularly reviewed and updated.

6.0 Quality Improvement Plan/Areas for Improvement

One new areas for improvement has been identified where action is required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments (July 2014).

	Regulations	Standards
Total number of Areas for Improvement	0	1

The area for improvement and details of the QIP were discussed with Mr Mark Regan, Responsible Individual and Ms Kelly Macartney, Registered Manager, as part of the inspection process. The timescale for completion commences from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments (July 2014)	
Area for improvement 1 **Ref:** Standard 16.2 **Stated:** First time **To be completed by:** 31 April 2025	The responsible individual shall appoint an external independent organisation or human resource advisor to undertake a cultural assessment of the hospital. An action plan should be generated to address any recommendations within the report detailing the main findings of the cultural assessment. Ref: 4.0
	Response by responsible individual detailing the actions taken: A staff survey was devised in the few days after the RQIA teams meeting on 21st February 2025 and included 11 questions to rate staff satisfaction in a number of areas and one free text area for advice on areas for improvement. This was made live to staff on 1st March 2025 and closed for further survey on 14th March 2025. The survey result were indpendantly audited by senior staf external. The findng were provided to Kelly Macartney on and Mark Regan on 3rd April 2025. A further group wide cultural assessment is ongoing with the Group Human Resources Manager. In 4 weeks time the Group will appoint a new Director of people and Culture.They will assist with the action plan on completion of the Group overall cultural assessment. Initial meeting with Department Managers took place on 27th February 2025 to discuss RQIA feedback. Some action points where discussed and implementation commenced immediately. The action plan for the survey result for Kingsbridge Private Hospital Belfast specifically is now in place. Key areas of focus: 1. Pay and Incentives 2. Workload, and staffing 3. Management and Communication 4. Career Development and Training 5. Patient Care and Safety 6 Facilities and Resources The first step in the action plan is using our "You Said/ We Did" notification to all staff to continually update on the actions taken to date and yet to come. Some focus groups have been arranged following specific staff group concerns. A meeting

	with department Managers and Deputies will take place to review the findings and set goals to achieve.

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

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