Announced Care Inspection Report
28-29 September 2016

Kingsbridge Private Hospital

Type of service: Independent Hospital – Surgical Services
Address: 811-815 Lisburn Road, Belfast BT9 7GX
Tel no: 02890667878
Inspectors: Winnie Maguire and Emily Campbell

1.0 Summary

An announced inspection of Kingsbridge Private Hospital took place on 28 September from 09:40 to 16:30 and 29 September 2016 from 9:30 to 15:00.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the independent hospital was delivering safe, effective and compassionate care and if the service was well led. The inspectors were accompanied by Dr Ian Gillan, RQIA's medical physics advisor on 28 September 2016. Dr Gillan's findings and report is appended to this report.

Is care safe?

Observations made, review of documentation and discussion with Mr Mark Regan , registered provider, Mrs Sarah Marks, registered manager, Ms Brenda Partridge, governance manager, staff and patients demonstrated in general, that systems and processes were in place to ensure that care to patients was safe and avoids and prevents harm. Areas reviewed included staffing, recruitment and selection, surgical services, laser safety, safeguarding, resuscitation and management of medical emergencies, infection prevention control and decontamination, and the general environment. Five recommendations were made in relation to the laser service.

Is care effective?

Observations made, review of documentation and discussion with Mr Regan, Mrs Marks, Ms Partridge, staff and patients demonstrated that systems and processes were in place to ensure that care provided in the establishment was effective. Areas reviewed included clinical records, the care pathway, patient information and decision making and discharge planning. No requirements or recommendations have been made.

Is care compassionate?

Observations made, review of documentation and discussion with Mr Regan, Mrs Marks, Ms Partridge, staff and patients demonstrated that arrangements are in place to promote patients' dignity, respect and involvement in decision making. Areas reviewed included dignity, respect and rights, informed consent, breaking bad news and patient consultation. No requirements or recommendations have been made.

Is the service well led?

Information gathered during the inspection evidenced that there was effective leadership and governance arrangements in place which creates a culture focused on the needs of patients in order to deliver safe, effective and compassionate care. Areas reviewed included organisational and staff working arrangements, the arrangements for policy and risk assessment reviews, the arrangements for dealing with complaints, incidents and alerts, insurance arrangements, the arrangements for managing practising privileges and the registered person's understanding of their role and responsibility in accordance with legislation. A recommendation was made to amend the statement of purpose; immediately following the inspection an electronic copy of an amended statement of purpose was forwarded to RQIA. This recommendation was addressed. Two further recommendations were made in relation to outlining the scope of practice for the medical practitioner in the practising privilege agreement and to include details of other professional bodies in the whistleblowing policy.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	7

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr Mark Regan, registered person, Mrs Sarah Marks, registered manager, and Ms Brenda Partridge, governance manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent care inspection

There were no further actions required to be taken following the most recent inspection on 17 February 2016.

2.0 Service details

Registered organisation/registered person: 3fivetwo Medical Ltd Mr Mark Regan	**Registered manager:** Mrs Sarah Marks
Person in charge of the home at the time of inspection: Mr Mark Regan	**Date manager registered:** 10 December 2013
Categories of care: Acute hospitals (with overnight beds)AH Acute Hospital (Day Surgery) AH(DS) Prescribed Technologies, Endoscopy PT(E) Prescribed Technologies, Laser PT(L) Private Doctor PD	**Number of registered places:** 22

Laser equipment

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

Laser protection advisor (LPA) - Ms Anna Bass (Lasermet)

Laser protection supervisor (LPS) - Mrs Aisling Green

Clinical authorised users - four named consultant ophthalmologists

Types of treatment provided - laser capsulotomy procedure

3.0 Methods/processes

Questionnaires were provided to patients and staff prior to the inspection by the hospital on behalf of the RQIA. Prior to inspection we analysed the following records: notification of reportable incidents, complaints declaration and returned completed patient and staff questionnaires. A number of staff questionnaires were received post inspection; their content was discussed with Mr Mark Regan following inspection.

During the inspection the inspectors met with Mr Mark Regan , registered provider, Mrs Sarah Marks, registered manager, Ms Brenda Partridge, governance manager, a theatre manager, a ward manager, three staff nurses, a nursing auxiliary, the laser protection supervisor, a clinical administrative manager, a contracts cleaning manager (spoken via the telephone), three patients, two relatives and briefly with a consultant. A tour of the premises was also undertaken.

Records were examined during the inspection in relation to the following areas:

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 12 September 2016

The most recent inspection of the Kingsbridge Private Hospital was an announced premises inspection. The report of this inspection will be issued in due course and any quality improvement plan (QIP) will be followed up by the estates inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 17 February 2016

No requirements or recommendations were made during this inspection.

4.3 Is care safe?

Staffing

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

Review of the duty rotas confirmed that there was adequate staff in place to meet the assessed needs of the patients accommodated at the time of inspection. Discussion with the theatre manager and the ward manager confirmed that the theatre list is reviewed and staff rostered accordingly to meet needs of patients. Staff confirmed that there are adequate staffing levels provided to meet the patient's needs on a 24 hour basis and that if necessary bank nurses are available who have experience working in the hospital.

Induction programme templates were in place relevant to specific roles within the hospital. A sample of four evidenced that induction programmes had been completed when new staff join the hospital. Staff confirmed they had undergone a robust induction programme including completion of a competency assessment framework commensurate with their role.

Procedures were in place for appraising staff performance and most staff confirmed that appraisals had taken place. One member of staff had not had an appraisal in over a year but confirmed arrangements were in place to undertake one in the coming weeks. Staff confirmed they felt supported and involved in discussions about their personal development. Review of a sample of four evidenced that appraisals had normally been completed on an annual basis.

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

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

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

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

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

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

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

Recruitment and selection

Ms Marks confirmed that five staff have been recruited since the previous inspection. A review of the personnel files for these staff and two consultant's personnel files demonstrated that most of the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained. One member of staff's file had two written references from the same referee. A further written reference from a different referee was provided during the inspection

There was a recruitment policy and procedure available. The policy was comprehensive and reflected best practice guidance.

Surgical services

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

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

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

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

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

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

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

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

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

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

- prevention of intra –operative hypothermia
- intra-operative fluid management – further information including a hospital policy on 'Intra-Cavity Fluids in Theatre – Policy on management and recording', was provided following inspection. It was advised theatre staff read and sign the policy confirming a clear understanding and implementation of its content.
- mass blood loss in theatre
- emergency line's box
- nurse in charge of theatre
- anaesthetist's role
- cleaning of theatres including deep cleaning

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

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

A review of a surgical register of operations, which is maintained for all surgical procedures undertaken in the hospital, found that it contained all of the information required by legislation.

Laser Safety

A laser safety file was in place which contains all of the relevant information in relation to laser equipment. It was suggested to declutter the laser safety file archiving information which is no longer current.

There was written confirmation of the appointment and duties of a certified laser protection advisor (LPA) which is reviewed on an annual basis.

Laser eye surgical procedures are carried out by authorised users who are consultant ophthalmologists in accordance with medical treatment protocols produced by a consultant ophthalmologist. Systems are in place to review the medical treatment protocols on an annual basis.

Up to date local rules are in place which have been developed by the LPA. The local rules contained the relevant information pertaining to the laser equipment being used.

The hospital's LPA completed a risk assessment of the premises. The recommendations made by the LPA have not been formally addressed and on review of the issues it was unclear what action needed to be taken. It was recommended to discuss the findings of the risk assessment, and the most recent LPA report with the hospital's LPA and take any action as necessary. The hospital's laser protection supervisor (LPS) confirmed during inspection a visit by the LPA had been arranged for November 2016

A list of clinical authorised users was maintained, however, it was found to be incomplete and all but one of the authorised users had signed to state that they have read and understood the local rules and medical treatment protocols. A recommendation was made to maintain a complete register of authorised users who sign they have read and understood the local rules and medical treatment protocols.

When the laser equipment is in use, the safety of all persons in the controlled area is the responsibility of the LPS. Arrangements are in place for another authorised user to deputise for the LPS in their absence, who is suitably skilled to fulfil the role.

The environment in which the laser equipment is used was found to be safe and controlled to protect other persons while treatment is in progress. The controlled area is clearly defined and not used for other purposes, or as access to areas, when surgery is being carried out.

The door to the laser suite is locked when the laser equipment is in use but can be opened from the outside in the event of an emergency.

The laser equipment is operated using a key. Arrangements are in place for the safe custody of the laser key when not in use.

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

Protective eyewear is available as outlined in the local rules for laser technicians/surgical assistants if required.

The hospital had a laser surgical register which was completed every time the equipment was operated and includes:

- the name of the person treated
- the date
- the operator

- the treatment given
- the precise exposure
- any accident or adverse incident

A review of the laser surgical register found some details not completed on a number of occasions. A recommendation was made to fully complete all fields of the laser register and establish an audit on the completion of the laser register.

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

The laser classification label must be clearly visible on the machine when the laser is in use. It was noted the laser classification label was hidden behind the side leaf of a laser table. It was recommended this matter is discussed with Sigmacon (supplier) and an additional label obtained and attached to the laser.

The records relating to application training and core of knowledge training were incomplete. A recommendation was made to provide evidence all authorised users have undertaken application training and have undertaken a core of knowledge update in the last five years.

Safeguarding

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

Review of records demonstrated that all staff in the establishment had received training in safeguarding children and adults as outlined in the Minimum Care Standards for Independent Healthcare Establishments July 2014.

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

Resuscitation and management of medical emergencies

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

A review of training records and discussion with staff confirmed that staff have undertaken basic life support training and updates and some nursing staff had received immediate life support training and updates. There is always at least one staff member with advanced life support training on duty at all times. It was confirmed the resident medical officer who provides 24 hour medical cover, has received adult and paediatric advanced life support training.

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

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

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

The policy for the management of medical emergencies reflected best practice guidance. Protocols were available for staff reference outlining the local procedure for dealing with the various medical emergencies.

Infection prevention control and decontamination procedures

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

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

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

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

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

A range of IPC audits have been carried out including:

- environmental
- hand hygiene
- surgical site infection

The compliance rate was noted to be high and an action plan was in place for areas of non-compliance.

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

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

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

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

Environment

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

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

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

A legionella risk assessment had been undertaken and water temperature is monitored and recorded as recommended.

Portable appliances testing had been carried out

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

Patient and staff views

Two patients submitted questionnaire responses to RQIA. Both indicated that they felt safe and protected from harm. Patients spoken to during inspection concurred with this. No comments were included in submitted patient questionnaire responses.

Fourteen staff submitted questionnaire responses. A number were submitted post-inspection. Thirteen indicated that they felt that patients are safe and protected from harm. The fourteenth staff member highlighted some issues in relation to pre-operative assessment. These matters were fully discussed with Mr Regan who agreed to review the issues raised. Staff spoken with during the inspection concurred with the majority of submitted staff questionnaires. Comments provided included the following:

- “Extensive and thorough questionnaires are completed for every patient to ensure safety.”
- “Safety is maintained to the best of our ability within the services provided.”
- “Could do with more storage for large equipment.”
- “Good, well trained staff.”
- “Very well trained and experienced clinical staff. Company endeavours to ensure all mandatory training is up to date”
- “Staff induction completed during a busy ward.”

Areas for improvement

Discuss the findings of the laser risk assessment and the most recent LPA report with the hospital’s LPA and take action as necessary.

Maintain a complete register of authorised users who sign they have read and understood the local rules and medical treatment protocols.

Fully complete all fields of the laser register and establish an audit on the completion of the laser register.

The laser classification label was hidden behind the side leaf of a laser table; this matter should be discussed with Sigmacon (supplier) and an additional label obtained and attached to the laser.

Provide evidence all authorised users of the laser have undertaken application training and have undertaken a core of knowledge update in the last five years.

Number of requirements	0	Number of recommendations	5

4.4 Is care effective?

Care pathway

Patients are provided with a comprehensive information pack prior to their admission which outlines any pre-operative requirements and the arrangements for their stay in the hospital. Copies of the patient guide are made available to all patients following admission.

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

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

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

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

- "I was provided with lots of information and everything was explained to me."
- "Very impressed by how we were treated"
- "Everyone was calm and reassuring "
- "The nurses and doctors were very good at explaining what was happening."

Records

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

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

Mrs Marks confirmed the hospital is registered with the Information Commissioner's Office (ICO).

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

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

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

Discharge planning

The hospital has a discharge policy and procedure in place.

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

One patient spoken with confirmed that they had been given clear instructions to follow on discharge and felt fully involved in the discharge process.

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

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

Patient and staff views

Both patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them. No comments were included in submitted staff questionnaire responses.

All submitted staff questionnaire responses indicated that they felt that patients get the right care, at the right time and with the best outcome for them. Staff spoken with during the inspection concurred with this. Comments within the staff questionnaires were largely positive however there were some comments in relation to post–operative communication and the information technology (IT) system which were discussed with Mr Regan who had already identified the shortcomings in the IT system and confirmed the matter was under review. Comments provided included the following:

- "The correlation of clinical records needs improvement... CRM is not suitable."
- "Patients have access to prompt care, a lot of one to one time and rapid investigation results. Care dealt with quickly and effectively."
- "Best practice is maintained and encouraged."
- "Audits carried out weekly/monthly and reviewed, any problems observed are acted on and learning given to staff."
- "Improve on the clarification of post op instructions at times."

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

Dignity, respect and rights

Discussion with management and staff regarding the consultation and treatment process confirmed that patient's modesty and dignity is respected at all times. In-patients are accommodated in single rooms with en-suite facilities. Screens are provided in the day procedure unit. Outpatients are provided in individual consultation rooms.

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

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

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

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

- "The staff are very good."
- "Staff very aware of my dignity when providing care."
- "They were all very supportive when I was waiting while my xxx was in theatre."
- "So friendly "

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

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

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

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

Breaking bad news

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

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

Staff confirmed that bad news is delivered to patients and/or their representatives by senior clinicians who have experience in communication skills and act in accordance with the hospital's policy and procedure.

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

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

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

Patient consultation

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

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

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

- "Staff were caring and efficient."
- "I was well cared for at all times."
- "My experience at Kingsbridge Private Hospital was a very pleasant one and very straightforward."

- “Excellent care.”
- “The staff were welcoming and were there if there was anything I needed.”
- “How quick and efficient staff were, and also very friendly.”

The information received from the patient feedback questionnaires is collated on a monthly basis into a summary report; which is made available to patients and other interested parties. It was suggested that future summary reports include the number of patients who took part in the survey.

Discussion with Mrs Marks and Ms Partridge confirmed that comments received from patients and/or their representatives are reviewed by senior management within the hospital and an action plan is developed and implemented to address any issues identified and used to improve the delivery of service.

Patient and staff views

Both patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care. No comments were included in submitted staff questionnaire responses.

All submitted staff questionnaire responses indicated that they felt that patients are treated with dignity and respect and are involved in decision making affecting their care. Staff spoken with during the inspection concurred with this. Comments provided included the following:

- “We strive to share pathways for patient care and delivery for the best outcome.”
- “Very much the majority of the staff.”
- “Regular audits and patient satisfaction surveys completed by patients.”

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.6 Is the service well led?

Management and governance arrangements

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

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

Policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, dated and systematically reviewed on a yearly to three yearly basis. It was suggested that the most recent date of policy review is included in the version control record of each policy. Staff spoken with were aware of the policies and how to access them.

Arrangements were in place to review risk assessments.

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

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

The following audits were reviewed:

- venous thromboembolism (VTE) risk assessment
- accidents and incidents
- complaints
- hand hygiene
- surgical safety checklist
- theatre documentation
- retrospective tonsillectomy
- urethral catheter documentation
- infection prevention and control internal and external audit
- post-operative nursing documentation
- peripheral cannulation
- controlled drugs

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

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

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

Five medical practitioner's personnel files were reviewed and confirmed that there was a written agreement between each medical practitioner and the establishment setting out the terms and conditions of practising privileges which has been signed by both parties. However, two of the records did not specify the scope of practice for which practising privileges were granted. A recommendation was made in this regard.

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

Kingsbridge Private Hospital has a policy and procedure in place which outlines the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges.

A whistleblowing policy was available. A recommendation was made that this is further developed to include reference to the various professional bodies that staff may refer to if appropriate. The details of Public Concern at Work should also be included as an avenue for staff advice and support. Discussion with staff confirmed that they were aware of who to contact if they had a concern.

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

A recommendation was made that the statement of purpose is updated and further developed as follows:

- reference to the Vanguard theatre and associated beds should be removed as it is no longer provided
- the arrangements made for the consultation with patients about the operation of the establishment should include the arrangements in place regarding patient satisfaction surveys
- the timescale for the acknowledgement of complaints should be reviewed to reflect the timescale in the complaints policy and procedure

This recommendation was addressed immediately following inspection and an electronic copy of an amended statement of purpose forwarded to RQIA.

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

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

Patient and staff views

Both patients who submitted questionnaire responses indicated that they felt that the service is well managed. Patients spoken with on inspection concurred with this. No comments were included in submitted patient questionnaire responses.

Twelve submitted staff questionnaire responses indicated that they felt that the service is well led. Two responses were not completed. Staff spoken with during the inspection concurred with the majority of the staff questionnaire responses. As stated previously some of the comments from the staff questionnaires were discussed with Mr Regan; who following inspection, confirmed the action taken and proposed to address the issues raised. He also confirmed a detailed staff survey would be conducted by the management of the hospital. Comments provided included the following:

- "I have no problem asking or enquiring about any aspects of the service. There is always someone at the end of an email, phone call or even to talk to"
- "Access to policies and procedures-ok."
- "Pre-operative assessment needs improvement."
- "All staff able to access policies and procedures."
- "There is well maintained information available to all staff with easy access if required."
- "Due to recent managerial transition – going through a period of adjustment."

Areas for improvement

Practising privileges agreements should specify the scope of practice for each medical practitioner for which practising privileges were granted.

The whistleblowing policy should be further developed to include reference to the various professional bodies that staff may refer to if appropriate. The details of Public Concern at Work should also be included as an avenue for staff advice and support.

Number of requirements	0	**Number of recommendations**	2

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Mark Regan, registered person, Mrs Sarah Marks, registered manager, and Ms Brenda Partridge, governance manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

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

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Independent Health Care Regulations (Northern Ireland) 2005, The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The DHSSPS Minimum Care Standards for Independent Healthcare Establishments(July 2014). They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to Independent.Healthcare@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 48.11 **Stated:** First time **To be completed by:** 28 November 2016	Discuss the findings of the laser risk assessment and the most recent laser protection advisor (LPA) report with the hospitals LPA and take action as necessary. **Response by registered provider detailing the actions taken:** An action plan has been completed and the results sent to the LPA
Recommendation 2 **Ref**: Standard 48.2 **Stated:** First time **To be completed by:** 28 October 2016	Maintain a complete register of authorised users who sign they have read and understood the local rules and medical treatment protocols. **Response by registered provider detailing the actions taken:** The consultant who had not signed the local rules has now signed. The register of users and signatures is complete.
Recommendation 3 **Ref**: Standard 48.9 **Stated:** First time **To be completed by:** 28 October 2016	Fully complete all fields of the laser register and establish an audit on the completion of the laser register. **Response by registered provider detailing the actions taken:** The importance of the completeness of this register has been reiterated to all relevant staff and consultants. The register will be signed as complete by the nurse in charge at the end of each session. The LPS will audit the register monthly for three months until there is 100% compliance and thereafter 6 monthly.
Recommendation 4 **Ref**: Standard 48.20 **Stated:** First time **To be completed by:** 28 October 2016	The laser classification label was hidden behind the side leaf of a laser table; this matter should be discussed with Sigmacon (supplier) and an additional label obtained and attached to the laser. **Response by registered provider detailing the actions taken:** Lumenis have been contacted and are supplying a new label which will also denote voltage and power
Recommendation 5 **Ref**: Standard 48.12	Provide evidence all authorised users of the laser have undertaken application training and have undertaken a core of knowledge update in the last five years.

Stated: First time **To be completed by:** 28 October 2016	**Response by registered provider detailing the actions taken:** The outstanding documents for Mr Kervick are attached
Recommendation 6 **Ref**: Standard 11.4 **Stated:** First time **To be completed by:** 28 October 2016	Practising privileges agreements should specify the scope of practice for each medical practitioner for which practising privileges are granted. **Response by registered provider detailing the actions taken:** These documents are being updated as they are implemented and reviewed
Recommendation 7 **Ref**: Standard 16.11 **Stated:** First time **To be completed by:** 28 October 2016	The whistleblowing policy should be further developed to include reference to the various professional bodies that staff may refer to if appropriate. The details of Public Concern at Work should also be included as an avenue for staff advice and support. **Response by registered provider detailing the actions taken:** This policy was updated on the 4th Oct to include the above. It was sent to the RQIA on the 20/10/16

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews