Announced Variation to Registration Inspection Report
28 and 29 October 2019

Kingsbridge Private Hospital

Type of Service: Independent Hospital – Acute Hospital
Address: 811-815 Lisburn Road, Belfast BT9 7GX
Tel No: 028 9066 7878

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

Membership of the Inspection Team

Jo Browne	Senior Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Dr John Simpson	Senior Medical Advisor Regulation and Quality Improvement Authority
Norma Munn	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Jean Gilmour	Inspector, Hospitals Programme Team Regulation and Quality Improvement Authority
Paul Nixon	Inspector, Pharmacy Team Regulation and Quality Improvement Authority
Helen Daly	Inspector, Pharmacy Team Regulation and Quality Improvement Authority
Raymond Sayers	Inspector, Estates Team Regulation and Quality Improvement Authority

2.0 Profile of the Hospital

Kingsbridge Private Hospital provides a wide range of surgical services, a minor injuries service, outpatients and a private general practice (GP) service. Adult and paediatric services are provided. The hospital is registered to accommodate up to 16 in-patients and six day surgery patients.

The hospital has two theatres, a dedicated endoscopy suite, a small x-ray department and a range of consulting rooms. The in-patient accommodation comprises of single en-suite rooms which are situated over two floors. The day surgery unit is located on the first floor of the premises.

3.0 Service details

Organisation/Registered Provider: 3fivetwo Medical Ltd **Responsible Individual:** Mr Mark Regan	**Registered Manager:** Ms Sarah Marks
Person in charge at the time of inspection: Ms Sarah Marks	**Date manager registered:** 10 December 2013
Categories of care: Independent Hospital (IH) – Acute hospital (with overnight beds) AH Acute Hospital (Day Surgery) AH(DS) Prescribed Technologies, Endoscopy PT(E) Prescribed Technologies, Laser PT(L) Private Doctor PD	**Number of registered places:** 16 inpatient beds increasing to 22 beds following this inspection. 6 day surgery beds

4.0 Inspection summary

We undertook an announced variation to registration inspection to Kingsbridge Private Hospital (KPH) over two days, commencing on Monday 28 October 2019 and concluding on Tuesday 29 October 2019.

An application for variation of the registration of KPH was submitted to RQIA on 6 January 2019 to increase the number of inpatient beds from 16 to 22 and to create a new medicines dispensary and a physiotherapy room where the administration centre had been previously located.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Independent Health Care Regulations (Northern Ireland) 2005, The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health, Social Services and Public Safety (DHSSPS) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

We employed a multidisciplinary inspection methodology during this inspection. We sought to assess progress with any issues raised during and since the previous inspection and to assess the application of variation to registration for an additional six in-patient beds and a medicines dispensary. During the inspection we were informed that work in relation to the physiotherapy room had not been completed and would not be included in this variation to registration application.

We identified good aspects in respect of the environment of the new ward, the layout of new medicines dispensary and the arrangements for medicines management on the new ward. We found some issues in relation to the environment and infection prevention and control (IPC) which required to be addressed before the new six bedded in-patient ward became operational. Following the inspection we received confirmation by email that the issues identified had been addressed.

We undertook a review of the current arrangements for governance and managerial oversight within the hospital specifically in relation to overarching governance structure, medical governance arrangements and management of incidents/events. We found that governance arrangements across the hospital had been strengthened following the previous inspection and the new structures were continuing to be developed and embedded.

The variation to registration of KPH to increase the inpatient beds from 16 to 22 and add a medicines dispensary was approved from a care, premises and pharmacy perspective following this inspection.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mr Mark Regan, Responsible Individual, Ms Sarah Marks, Registered Manager and the Nurse Clinical Lead as part of the inspection process and can be found in the main body of the report.

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

4.2 Action/enforcement taken following the most recent inspection dated 24 and 25 July 2018

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 24 and 25 July 2018.

5.0 How we inspect

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

- notifiable events since the previous inspection;
- registration status of the establishment;
- written and verbal communication received since the previous inspection;
- the previous inspection report;
- QIP returned following the previous inspection; and
- application received to vary registration of KPH.

During our inspection, we met with the following staff: Mr Mark Regan, Responsible Individual, Ms Sarah Marks, Registered Manager, the Nurse Clinical Lead, the Estates and Facilities Manager, the Ward Manager, nursing staff, healthcare assistants and cleaning staff. We inspected the new six bedded ward and the medicines dispensary; a sample of records were examined in relation to each of these areas inspected.

We provided detailed feedback on our inspection findings as described in section 4.1.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection dated 24 and 25 July 2018

The most recent previous inspection of the hospital was an unannounced multi-disciplinary inspection. The completed QIP was returned and approved by the relevant inspectors.

6.2 Review of areas for improvement from the previous care inspection dated 24 and 25 July 2018

Areas for improvement from the previous inspection		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 15 (6) **Stated:** First time	The registered person shall review and refresh the current system for auditing and assuring contents of resuscitation trolleys, to ensure the system is more robust. Particular attention should be paid to recording of expiry dates of emergency medications and that equipment checklists accurately reflect actual items stored on the resuscitation trolleys.	**Met**

	Action taken as confirmed during the inspection: We were informed that the management of the resuscitation trolleys has been assigned to one registered nurse. We found that the emergency medicines held were in line with the British National Formulary (BNF) and emergency equipment was available as recommended by the Resuscitation Council (UK). Guidance on the contents of the resuscitation trolleys had also been obtained from the Belfast Health and Social Care Trust. We checked the resuscitation trolley in Ward 1 recovery and found that the contents of the trolley, including emergency medicines, were checked twice daily to ensure that expiry dates were not exceeded. Expiry dates were clearly recorded for emergency medicines.	
Area for improvement 2 **Ref**: Regulation 15 (5) **Stated:** First time	The registered person shall implement a system to audit and assure decontamination procedures in respect of endoscopes, to ensure decontamination of scopes is in keeping with best practice guidance.	**Met**
	Action taken as confirmed during the inspection: We were informed that automated cleaning and disinfection of endoscopes is no longer carried out in KPH. Manual cleaning of endoscopes is undertaken in KPH immediately following a procedure. The endoscope is then transported securely to Central Sterile Services Department (CSSD) in the South Eastern Health and Social Care Trust (SEHSCT) for automated cleaning and disinfection. We were unable to observe the practice of manually decontaminating of endoscopes as there were no endoscopic procedures being carried out at the time of our inspection. We observed policies and procedures in place to support staff when carrying out manual decontamination of endoscopes. We observed that a computerised endoscope instrument tracking and traceability system was in place and interfaced to patient records to support the robust traceability of all	

	endoscopes.	
Area for improvement 3 **Ref**: Regulation 18(2) (a) **Stated:** First time	The registered person shall ensure that staff responsible for decontamination of endoscopes have completed refresher training in keeping with best practice guidance.	**Met**
	Action taken as confirmed during the inspection: We reviewed training records and found that training and competency assessments for the manual decontamination of endoscopes is routinely undertaken by staff commensurate to their role.	
Area for improvement 4 **Ref**: Regulation 15 (1) (a) & (b) **Stated:** First time	The registered person shall review the current system for completion of pre-operative medical questionnaires, to ensure it is clear and understood by patients.	**Met**
	Action taken as confirmed during the inspection: We found that the pre-operative medical questionnaires had been reviewed and several of the questionnaires had been amended to ensure that information required by the hospital is clearly understood by patients.	
Area for improvement 5 **Ref**: Regulation 17 **Stated:** First time	The registered person shall address the following matters with respect to the Medical Advisory Committee (MAC): • Ensure the committee meets on a quarterly basis (as a minimum) and arrangements are in place for extraordinary meetings as necessary; • Ensure that the committee is reviewing information in respect of adverse clinical incidents and is advising the hospital's senior management team on corrective action when/as necessary; • Ensure the committee is assisting the senior management team to assure and evidence safe practice • Ensure the committee is providing the expertise to discuss and if necessary challenge practice of individual medical practitioners; and • Minutes of MAC meetings must accurately reflect discussions progressed, actions agreed and persons responsible for taking	**Met**

	forward actions within agreed timescales.	
	Action taken as confirmed during the inspection: We reviewed the role and function of the MAC and evidenced through the review of documentation and discussion with key personnel that all previous issues identified in relation the MAC had been addressed. We found that the MAC was meeting at least quarterly and were advised that extraordinary meetings can be called if necessary. We were informed that teleconferencing and video conferencing facilities are available to enable MAC members to join the meeting remotely. We found evidence of the MAC directing and challenging clinical practice within the hospital e.g. policy and guidelines being endorsed by the committee and discussions around individual consultant's clinical practice being undertaken with agreed actions recorded. The MAC is involved in directing the hospital's audit programme to assure and evidence safe practice. Quality Indicators (QI) and the results of audits and clinical audits are presented to the MAC. The committee reviews the results of the QIs and audits and make recommendations on any action plans required to address the QI and audit outcomes. We found the minutes of MAC meetings clearly documented all discussions progressed, actions agreed and the person responsible for taking forward the actions within agreed timescales.	
Area for improvement 6 **Ref**: Regulation 28 **Stated:** First time	The registered person shall address the following matters with respect to incident management: • Review the current system, which is currently dependent on two members of staff, to ensure the expertise is shared more widely, to build a sustainable approach across the KPH; • Review the current system of incident investigation and management to ensure it	**Met**

	is balanced between reviewing equipment, procedures and clinical practice; and • Disseminate the learning, from incidents, across all staff groups. The registered person shall address the following matters with respect to notifications: • Ensure that RQIA is informed of all incidents, in a timely manner, in keeping with the guidance statutory notifications of incidents and deaths for registered providers and managers ; • Ensure that the information sent to RQIA is sufficient in detail; and • Amend the current system for reporting to RQIA, via web portal, from one which is overseen by one person, to one that can be operated by more than one person.	
	Action taken as confirmed during the inspection: We reviewed the management of incidents and found that progress had been made to address the issues previously identified. We were advised that KPH has introduced a team of senior staff to manage incidents which includes the Responsible Officer, a Consultant Anaesthetist, Registered Manager, Clinical Governance Manager, Clinical Nurse Lead and Patient Safety Nurse. We found that the management of incidents had been strengthened since the previous inspection. Incidents were risk assessed and RAG rated action plans developed. We reviewed incident investigations and found that they included: what happened; immediate corrective actions; why did it happen; what has been learned; and what has been changed. We found that incident investigations were balanced between reviewing equipment, procedures and clinical practice. We could see that incidents are discussed at the MAC and departmental meetings and the MAC provided guidance and/or challenge in relation to clinical practice. Learning outcomes from incidents was included in	

	weekly safety briefs and displayed in staff only areas within KPH. We reviewed incidents which had occurred since the previous inspection and found that all incidents had been reported to RQIA in a timely manner, in keeping with the legislation and RQIA guidance. We were advised that members of the incident management team have been given permissions by the Responsible Individual to report incidents to RQIA via the web portal.	
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 16.1 **Stated:** First time	The registered person shall ensure that responsibilities for clinical governance are reviewed and clearly delineated to ensure there is no ambiguity with respect to who has overall responsibility for clinical governance, operational management and any other relevant roles within the hospital. All roles need to be clearly defined and specified.	**Met**
	Action taken as confirmed during the inspection: We reviewed the minutes of the monthly Quality & Governance meetings, quarterly MAC Meetings and the quarterly Group Quality and Governance meetings. We discussed the governance structures with key personnel who were able to clearly define the role and function of the various committees and personnel involved in governance. We found that the clinical governance arrangements within the hospital had been strengthened and there were clear lines of accountability for clinical governance, operational management and other roles within the hospital. We advised that for clarity, consideration should be given to developing a flow chart outlining the governance structures within the hospital and making this accessible to all staff.	

Area for improvement 2 **Ref**: Standard 16.1 **Stated:** First time	The registered person shall ensure that the role and function of the Clinical Governance Steering Group and Assurance Committee is clearly described and delineated from the role and function of the Medical Advisory Committee.	**Met**
	We found that the Clinical Governance Steering Group and Assurance Committee meet quarterly and is clearly described and delineated from the role and function of the MAC.	
Area for improvement 3 **Ref**: Standard 13.9 **Stated:** First time	The registered person shall ensure that operational arrangements are in place to assure staff appraisals are undertaken annually and a record is maintained.	**Met**
	Action taken as confirmed during the inspection: We reviewed the arrangements for undertaking staff appraisals. A random sample of staff appraisals reviewed demonstrated that these had been undertaken annually and a record maintained.	
Area for improvement 4 **Ref**: Standard 12.7 **Stated:** First time	The registered person shall ensure that operational arrangements are in place to ensure that minutes of staff meetings are disseminated in a timely manner and that they also evidence dissemination/sharing of learning.	**Met**
	Action taken as confirmed during the inspection: We reviewed the arrangements in place to ensure that minutes of staff meetings are disseminated in a timely manner and that they also evidence dissemination/sharing of learning. Examination of a random sample of staff meeting minutes confirmed that dissemination/sharing of learning was recorded. We were informed that minutes are made available for staff in a timely manner.	

6.3 Inspection findings

Clinical and organisational governance

We undertook a review of the current arrangements for governance and managerial oversight within the hospital specifically in relation to overarching governance structure, medical governance arrangements and management of incidents/events. We found that governance arrangements across the hospital had been strengthened following the previous inspection and that the new structures and processes were continuing to be developed and embedded. We advised that, for clarity, consideration should be given to developing a flow chart outlining the governance structures within the hospital and making this accessible to all staff.

Statement of Purpose and Patient Guide

We reviewed the Statement of Purpose and Patient Guide to ensure compliance with relevant legislation. We found that they were prepared in a recognised format which covered the key areas and themes as outlined in The Independent Health Care Regulations (Northern Ireland) 2005.

Staffing

We reviewed the staffing arrangements in the hospital and found there was a multi-professional team working in the hospital including Consultant Surgeons; Consultant Physicians; Consultant Ophthalmologists; Consultant Anaesthetists who have practising privileges agreements in place and Nurses; Radiographers; and other Allied Health Professionals who are directly employed by KPH. A Resident Medical Officer (RMO) is available on site to provide medical cover and to meet the assessed needs of patients accommodated in the hospital.

We were informed that sufficient staff have been recruited, in various roles, to meet the needs of the patients who will be accommodated in new six bedded unit.

Recruitment and selection

We reviewed the arrangements for recruitment and selection of staff to ensure compliance with relevant legislation and best practice guidance. We found that a number of staff of various grades and professions have been recruited to work in the new six bedded unit since the previous inspection. A random sample of four personnel files of newly recruited staff demonstrated that AccessNI enhanced checks and all other information required by legislation had been sought and retained with the exception criminal conviction declarations under Article 3 of the Rehabilitation of Offenders (Northern Ireland) Order in respect of two staff. We discussed this with Ms Marks and we were informed that criminal conviction declarations will be sought in respect of all new staff recruited in the future.

Resuscitation and management of medical emergencies

We were informed that one registered nurse has been designated the responsibility for coordinating the management of the resuscitation trolleys. We found that the emergency medicines held were in line with the British National Formulary (BNF) and emergency equipment was available as recommended by the Resuscitation Council (UK). Guidance on the contents of the trolleys had also been obtained from the Belfast Health and Social Trust.

We checked the resuscitation trolley in Ward 1/ Recovery and found that the contents of the trolley, including emergency medicines, were checked twice daily by the nursing staff to ensure that expiry dates were not exceeded. Expiry dates for emergency medicines were clearly recorded.

Medicines management and the new medicines dispensary

We reviewed the layout of new dispensary and the arrangements for medicines management on the new six bedded ward.

An inspector from the Medicines Regulatory Group at the Department of Health had already inspected and approved the new medicines dispensary from their perspective and the associated Standard Operating Procedures. The purpose of the new medicines dispensary was to provide a single area to facilitate the efficient distribution of medicines to the various departments in the hospital.

We were informed that the hospital was in the process of recruiting a pharmacist. The pharmacist's responsibilities will include:

- ensuring that all practice relating to the management of medicines is in adherence with current legislation, professional standards and guidelines;
- providing up to date policies on all areas of the management of medicines, including Standard Operating Procedures for controlled drugs;
- ensuring the pharmacy is cost effective;
- ensuring best practice in prescribing and administering medicines;
- ensuring the safe handling and distribution of medicines throughout the hospital and in clinical areas;
- providing advice on waste management;
- leading on antimicrobial stewardship;
- developing an auditing system for medicines management;
- management of medication related incidents; and
- provision of an out of hours pharmacy service, when necessary.

We found that the arrangements for the storage of medicines in the new ward were satisfactory. We were advised that the arrangements for medicines management in the new ward would be the same as those already operating in the existing wards of the hospital.

Infection prevention and control

We reviewed the arrangements for infection prevention and control (IPC) and decontamination procedures in relation to the new six bedded ward, to ensure the risk of infection for patients, visitors and staff are minimised.

We were informed that an IPC link nurse had been appointed, their role being to support staff with IPC issues. We were informed that nursing staff attend the regional IPC Group meetings and subsequently share their knowledge with other staff in the hospital. All staff working in the new ward will have undertaken IPC training commensurate with their role.

We found that the new ward was generally clean, tidy and well equipped. However, we identified that the following issues require to be addressed:

- Infection prevention and control information and hand hygiene posters for patients and staff should be displayed in the clinical areas;
- All wall mounted hand soap dispensers and toilet roll holders should be well stocked;
- A deep clean of each bedroom and identified areas should be undertaken;
- Provide sufficient waste bins in en-suites;
- Ensure that towels for patient use in en-suites are not stored on top of the toilet cisterns;
- Provide clinical waste bins in the sluice area; and
- Ensure that chemicals stored in the sluice are stored safely in keeping with Control of Substances Hazardous to Health 2002 regulations (COSHH).

Following the inspection we received confirmation from Ms Marks that the issues identified in relation to IPC had been addressed. We were informed that additional IPC advice and guidance had been sought from an independent advisor with specialist IPC expertise, an audit had been undertaken, an action plan devised and assurances were given that any issues identified would be addressed prior to the six bedded ward becoming operational.

Environment

We reviewed the new medicines dispensary, nurses station and six bedded ward as specified in the variation to registration application design details. During the inspection we were informed that work on the physiotherapy room had not been completed and would not be included in this variation application.

Statutory approval documents submitted by building control and planning authorities were reviewed, confirming that valid consents for the construction work had been received.

The consultant building services engineer confirmed to us in writing that project design complied with: Health Technical Memorandum (HTM) 02 medical gas pipeline systems; HTM 03 ventilation system; HTM 04 water safety; HTM 05 fire safety and HTM 06 electrical services. We reviewed the installation and commissioning validation certificates for: medical gas, electrical installation, emergency lighting, fire detection & alarm system, and recorded them as compliant with recommended standards.

A number of minor building fabric snagging items were recorded as requiring remedial attention. We received confirmation of completion of the corrective works by the submission of digital images via e-mail on 12 November 2019.

We reviewed certificates verifying that the chlorination of the water distribution systems was completed on 11 October 2019. We reviewed thermostatic mixing valve (TMV) installation/commissioning verification certificates for the new accommodation and confirmed this was completed on 11 October 2019.

The water safety/legionella risk assessment was reviewed by the KPH water safety risk assessor, and amended to incorporate the new accommodation.

There were no areas for improvement identified as a result of the premises inspector`s assessment of the new accommodation.

6.4 Conclusion

The variation to registration to increase the inpatient beds from 16 to 22 and add a medicines dispensary was approved from a care, premises and medicines management perspective following this inspection. The physiotherapy room was not assessed during this inspection and approval for this room has not been granted.

7.0 Quality improvement plan

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

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