The Regulation and Quality Improvement Authority

Inspection Report

01 & 02 December 2021

Hillsborough Private Clinic

Type of service: Independent Hospital – Surgical Services
Cromlyn House, 2 Main Street, Hillsborough BT26 6AE
Telephone number: 028 9268 8899

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 Establishments (July 2014)

1.0 Service information

Organisation/Registered Provider: Cromlyn House Surgical Ltd. **Responsible Individuals:** Mr Gary McKee Mr James Sharkey	**Registered Manager:** Ms Ruth Collins (Acting)
Person in charge at the time of inspection: Ms Ruth Collins	**Date manager registered:** Registration pending
Categories of care: (IH) Independent Hospital AH(DS) - Acute Hospital (Day Surgery) PD - Private Doctor PT (L) - Laser PT (E) – Endoscopy	
Brief description of the accommodation/how the service operates: Hillsborough Private Clinic provides a wide range of services and treatments, including outpatient services across a range of medical specialties; diagnostic tests and investigations and some surgical day case procedures.	

2.0 Inspection summary

An unannounced inspection was undertaken to Hillsborough Private Clinic on 01 December 2021, and concluded on 14 December 2021, with feedback to Ms Ruth Collins, Registered Manager (RM), and Mr Gary McKee, Responsible Individual (RI).

The clinic was inspected by a team comprised of care inspectors, a medical practitioner and an estates inspector.

Hillsborough Private Clinic was acquired by the Affidea Group during 2021. The Affidea Group is a provider of diagnostic imaging and outpatient care services**.** The RI advised us that the management structure within the clinic has been unaffected as a result of this acquisition.

The inspection focused on eight key themes: governance and leadership; patient care records; surgical services; safeguarding; staffing; environment and infection prevention and control (IPC); and estates.

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of incidents and alerts and the arrangements for managing practising privileges. There was evidence of good communication systems to ensure key information is received by staff and there was confirmation that patients were treated with compassion, dignity and respect. Review of estates management evidenced that suitable arrangements are in place for maintaining the environment in accordance with current legislation and best practice guidance.

Some areas of concern and practical measures for improvement were brought to the attention of staff and the RM during the inspection and during feedback.

Four areas for improvement (AFIs) were identified during the inspection in relation to unannounced monitoring visits undertaken by the RI, staff training, completion of staff annual appraisals and comprehensive risk management procedures in relation to IPC.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

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

- the registration status of the establishment;
- written and verbal communication received since the previous inspection;
- the previous inspection reports;
- QIPs returned following the previous inspections;
- notifications;
- information on concerns;
- information on complaints; and
- other relevant intelligence received by RQIA.

Inspectors assessed practices and examined records in relation to each of the areas inspected and met with a range of staff, including the manager, nursing and administrative staff.

Posters informing patients, staff and visitors of our inspection were displayed while the inspection was in progress. Staff and patients were invited to complete an electronic questionnaire during the inspection.

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

4.0 What people told us about the service

Patient feedback confirmed they were happy with their care, they felt it was safe and effective, and they were treated with compassion.

Staff told us they work in a supportive team and receive good support from the RM and clinical sisters within the clinic. They felt listened to and were able to raise concerns. They reported challenges as a result of the COVID 19 pandemic including an increasing busy working environment and challenges with staff recruitment similar to all sectors across health and social care. Staff described the care within the clinic as compassionate and patient safety was paramount.

One staff electronic questionnaire was received which indicated a high level of satisfaction that patient care delivery was safe and effective and the service was well led.

5.0 The inspection

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

The previous inspection to Hillsborough Private Clinic was undertaken on 08 March 2021; no areas for improvement were identified during this inspection.

5.2 Inspection findings

5.3 Governance and Leadership

5.3.1 Clinical and Organisational Governance

It was established that effective governance systems are in place within the clinic supported by effective communication. There was a clear organisational structure and staff were able to describe their role and responsibilities. The RM has overall responsibility for the day to day management of the clinic.

Quarterly Medical Advisory Committee (MAC), meetings were taking place, minutes were available and action plans were documented where necessary. Standing agenda items are discussed including complaints and compliments, incidents, post-operative complications and staffing issues. It was noted that any practicing privileges required for a medical practitioner to work in the clinic are reviewed and granted at this meeting.

Policies and procedures were available for staff reference and found to be dated and systematically reviewed. New policies and procedures or those due for review are scrutinised through the clinics governance systems and shared with relevant staff.

A rolling audit programme is in place, including auditing of hand hygiene, care records, endoscope procedures and incident management.

Audit results are also reviewed through the clinics governance systems and disseminated to staff. Overall auditing outcomes and action plans to address deficits were devised although it was noted that a required action plan was not present to address the findings from an Infection Prevention Control (IPC) audit. Additionally, auditing criteria for complaints management was brief and could be further strengthened by additionally auditing practice against the clinics own complaints policy/procedure. This was raised during the inspection and assurance was provided from the RM that these two areas would be addressed.

The RQIA certificate of registration was up to date and displayed appropriately. Examination of insurance documentation confirmed that insurance policies were in place and up to date.

The clinic maintains a corporate risk register which collates risks in relation to areas of the clinic that have the potential to impact on the delivery of services. Review of the risk register confirmed that risks were effectively identified and robust action plans were in place to mitigate against identified risks.

In accordance with Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005, where the entity operating a hospital is a corporate body or partnership or where an individual owner is not in day-to-day management of the hospital, unannounced quality monitoring visits must be undertaken and documented every six months. Reports of the unannounced monitoring visits should be retained and made available to RQIA and those outlined within the regulation. Whilst the RM informed us that an unannounced monitoring visit had taken place during May 2021 there was no report of this visit available during the inspection. An AFI has been made in this area and this will further strengthen the governance arrangements within the hospital.

5.3.2 Practicing Privileges

Arrangements were reviewed relating to the practicing privileges for medical practitioners working within the clinic and it was confirmed that systems are in place to appraise practising privileges agreements every two years. A practicing privileges policy and procedure is in place which outlines the arrangements for application, granting and maintenance for practicing privileges. A sample of staff files were observed and this confirmed that all relevant documentation was present in relation to professional indemnity, insurance and medical appraisals for these doctors.

5.3.3 Communication

While staff meetings have stopped during COVID 19 pandemic due to difficulties maintaining social distancing the RM reported that monthly directors meetings continue to take place and there is clear dissemination and communication of information with staff directly, through emails, staff notice boards and staff safety briefs. The RM reported the recommencement of regular staff meetings was a priority when these could take place safely.

A process for the dissemination and implementation of Regional and National Guidance, urgent communications, safety alerts, and notices was in place to ensure all patient safety communications received, were distributed to key staff and actioned appropriately in a timely manner.

5.3.4 Complaints Management

The clinics complaints policy is made available to patients and their representatives. All complaints are raised through the clinics governance systems and complaints are audited to identify any trends that require further action to improve care and service delivery. It was established that any complaints received were investigated and responded to. Observed complaints records evidenced details of all communications with complainants, the results of any investigation, the outcome and any actions taken or required to address the concern.

The clinic obtains the views of patients and/or their representatives on a formal basis as an integral part of the service they deliver. On review of the recent patient satisfaction survey the results demonstrated a high proportion of patients were highly satisfied with the care and treatments they received. It was noted that relevant patient feedback was used to develop action plans to address any issues identified where improvement was required.

5.3.5 Notifiable Events/Incidents

The arrangements in respect of the management of notifiable events/incidents and the notifications submitted to RQIA since the previous inspection were reviewed. It was confirmed that a system was in place to ensure that notifiable events were investigated and reported to RQIA in line with the Independent Healthcare Regulations (NI) 2005, and other relevant bodies as appropriate. Reported notifiable events and incidents are discussed at MAC meetings.

5.4 Patient Care Records

The clinic is registered with the Information Commissioners Office (ICO). The clinic has a range of policies and procedures in place for the management of records and clinical record keeping. Records were found to be well organised and stored in a secure environment. A policy is in place for the retention and storage of records.

A range of patient care records were examined during the inspection including admission records, intra operative records and discharge information. The records included comprehensive assessment of patient needs identified on admission and care plans demonstrated ongoing assessment and evaluation of patient care.

Patient consent documentation and pain assessment and management was evident within care records. Patients are provided with discharge advice on ongoing care and where to seek further help in the event of any difficulties.

It was noted there were missing signatures on three care records, the surgical safety checklist was not fully completed for one care record and patient's identification details were not fully recorded in all required areas within two care records. It is acknowledged that the clinic conducts a notes audit to identify any deficits in record keeping that require action plans to improve practice. This auditing criteria should be reviewed to ensure these identified areas are fully captured during auditing and any deficits are addressed. This was brought to the attention of the RM during the inspection and during inspection feedback with assurance provided that auditing criteria will be reviewed and amended if necessary.

5.5 Surgical Services/ Theatres

A review of the arrangements for the provision of surgery in the clinic found them operating under their statement and purpose and categories of care. Review of surgery arrangements evidenced that the theatres were operating effectively in accordance with best practice and national standards to ensure care delivery is safe and effective.

The scheduling of patients for surgical procedures is co-ordinated by the consultant surgeon, anaesthetist, theatre sister and administrative staff. Scheduling takes into account individual patient requirements, staffing levels, the nature of the surgical procedure and any associated risks. Patients are observed during and after surgery by appropriately trained staff.

A surgical register of operations is maintained for all surgical procedures undertaken in the clinic. On review of the register it was found to contain the relevant information required by legislation.

There is an identified member of nursing staff, with relevant experience, in charge during all procedures. Staff complete a surgical safety checklist based on the World Health Organisation (WHO) guidance and completion of the surgical checklist and compliance is routinely audited through the clinics notes auditing process.

Patients were observed to receive the assistance they required and were treated with compassion. Patients are provided with the necessary information regarding their planned procedure and were observed to receive clear and concise post procedure advice with opportunity to discuss any concerns and ongoing care.

Resuscitation equipment is readily available and a system is in place to ensure it is checked, that equipment in good working order and it is restocked.

Appropriate equipment decontamination processes were found to be in place and there are links with Trust hospitals for equipment provision and the decontamination of equipment where required.

5.6 Safeguarding

Arrangements for safeguarding of children and adults were reviewed. Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm, and in line with the regional 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015); Adult Safeguarding Operational Procedures (2016); and 'Co-operating to Safeguard Children and Young People in Northern Ireland' (August 2017). Policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or a child.

Staff receive training in safeguarding children and adults as outlined in the Minimum Care standards for Independent Healthcare Establishments 2014. Staff were knowledgeable in the actions to be taken should a safeguarding incident be identified and they were able to identify the nominated safeguarding lead within the clinic.

It was confirmed that the clinic provides services to children for outpatient appointments only. No procedures are carried out on children within the clinic.

5.7 Staffing

Staffing arrangements were reviewed within the clinic and the staffing complement and skill mix was found to be in line with patient needs. There was evidence of forward planning when staff vacancies arise and recruitment for vacant posts within the clinic was found to be in progress.

A random sample of personnel files, which included newly recruited staff, demonstrated that the information required by legislation had been sought and retained through the recruitment and selection process.

Staff described effective sharing and dissemination of information through safety briefs, minutes, and emails. Audit results, action plans and incidents are shared to promote learning and improve practice.

A staff training matrix is maintained and kept under review by the RM. It was noted that staff training was not up to date in all areas with specific deficits for up to date training in data protection, paediatric life support and aseptic non touch technique (ANTT) training. On discussion with the RM it was established that deficits in staff training had been identified with plans to address. An area for improvement has been made in this area to provide assurance that staff training is completed and up to date.

Appropriate supervision and appraisal systems are required to support continuous professional development and ongoing learning for staff. An up to date staff supervision and staff appraisal policy was in place within the clinic. Whilst staff reported they received informal supervision, formal supervision was not up to date. It was also noted that all staff had not received an annual appraisal. This was discussed during the inspection and the RM reported these deficits have been identified and assurance was provided during the inspection that the completion of regular staff supervision and appraisal would be actioned as a priority in line with the clinics policy.

The completion of annual staff appraisals has been identified as an area for improvement to ensure staff have a recorded appraisal to review their performance against their job description and to agree personal development plans

5.8 Environment/Infection prevention and Control

Overall the environment and equipment were in a good state of repair, with a high standard of cleaning throughout the clinic. It was noted that staff are vigilant with the adherence and monitoring of IPC measures to maintain a COVID 19 safe environment.

Hand sanitizer was available at all key points of care within the clinic, and staff were observed to carry out appropriate hand hygiene practices. Staff were noted to be compliant with dress code policy in line with best practice recommendations. Personal protective equipment (PPE) was accessible and worn by staff in line with current guidance.

Equipment cleaning schedules were in place and there is a rolling programme of IPC auditing including hand hygiene and environmental auditing. The results of these audits, and related action plans, are shared with staff.

A number of open bins and pedal operated bins were observed within consultation rooms and within the diagnostic room. The use of open bins in clinical areas does not comply with current advice and guidance in relation to the safe management of healthcare waste. This was highlighted during the inspection with assurance provided that all open bins would be removed from these areas.

It was observed that a diagnostic room was being used to carry out a nasal endoscope procedure and was also used as a multipurpose room. The room was found to be cluttered and concerns were raised with the RM during the inspection regarding the arrangements for environmental decontamination of the room and PPE arrangements whilst the procedure was carried out. Staff reported that external IPC advice had been sought prior to the use of the diagnostic room for this specific procedure, although, there were no available risk assessments to provide assurance the procedure was carried out in line with best practice guidance.

It was reassuring that the RM changed the location of this procedure during the inspection and made arrangements for further external IPC advice to ensure the correct risk assessments and environmental decontamination arrangements were in place. An area for improvement has been made in this area with reference to the requirement for a comprehensive risk management assessment.

5.9 Estates

The following documentation was reviewed in relation to the maintenance of the premises including the mechanical and electrical installations. Discussion with staff demonstrated that suitable arrangements are in place for maintaining the environment in accordance with current legislation and best practice guidance.

- 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 relating to staff fire safety training
- records of fire drills undertaken
- Lifting Operations and Lifting Equipment Regulations (LOLER) 'Thorough Examination' reports of the premises' stair lifts
- condition report for the premises' fixed wiring installation
- report for the formal testing of the premises' portable electrical appliances
- the Legionella Risk Assessment
- service records, validation checks and audits for the premises' specialist ventilation systems.

The most recent Legionella Risk Assessment was undertaken on 30 June 2020 and all required remedial works were completed on 1 August 2020. Suitable temperature monitoring of the premises' hot and cold water systems was in place with records being maintained as

recommended. A full chemical treatment of the premises' hot and cold water systems was undertaken on 28 July 2021. Regular bacteriological sampling of the hot and cold water systems most recently undertaken on 21 October 2021 confirmed that legionella and pseudomonas bacteria were not detected.

The Fire Risk Assessment had been undertaken by a suitably accredited fire risk assessor on 16 April 2021. The overall assessment was assessed as 'tolerable' and no significant findings were identified. Through discussion with staff and review of the records we confirmed suitable fire safety training was delivered on 5 March 2021 and that bank staff receive suitable training during their induction. The most recent fire drill for the premises had been completed on the 30 March 2021.

The premises' specialised ventilation systems are serviced in accordance with current best practice guidance and 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.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Minimum Care Standards for Independent Healthcare Establishments (July 2014).

	Regulations	Standards
Total number of Areas for Improvement	2	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Ruth Collins (RM) and Mr Gary McKee (RI), as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 26 **Stated:** First time **To be completed by:** 31 January 2022	The registered persons shall ensure unannounced quality monitoring visits are undertaken and documented every six months. Ref: 5.3.1
	Response by registered person detailing the actions taken: A bi annual reminder is in place to ensure the frequency of unannounced monitoring visits. Unannounced monitoring visits will inform a component of the agenda at quarterly MAC meetings. A record of unannounced monitoring visit will be retained and reviewed at MAC meeting

	An unannounced monitoring visit has taken place since inspection. Quality Lead will also undertake unannounced monitoring visit indenpendently in addition to the registered persons.
Area for improvement 2 **Ref:** Regulation 18 (2) **Stated:** First time **To be completed by:** 31 March 2022	The registered persons shall ensure that all staff receive up to date mandatory and other appropriate training as required. Ref: 5.7
	Response by registered person detailing the actions taken: Acessibility to training has been difficult during the pandemic. a robust system is in place to monitor training and when this needs reviewed. Outstanding training has been identified and priority given to ANTT, Paediatric life support and GDPR training.
Action required to ensure compliance with The Minimum Care Standards for Independent Healthcare Establishments (2014)	
Area for improvement 3 **Ref:** Standard 13.9 **Stated:** First time **To be completed by:** 31 March 2022	The registered persons shall ensure staff receive up to date annual appraisal to review their performance against their job description and agree personal development plans. Ref:5.7
	Response by registered person detailing the actions taken: To date the majority of staff have had an annual appraisal, a schedule is in place for the remaining appraisals to be completed. An appraisal cycle has been implemented for the new financial year and greater responsibility delegated to the sisters of each department to undertake both supervision and appraisal. We also await further guidance as we integrate with Affidea and are cognisant that we may need to reflect appraisal cycle.

Area for improvement 4 **Ref:** Standard 17.1 **Stated:** First time **To be completed by:** 31 January 2022	With reference to any clinical procedures carried out in the diagnostic room. The registered persons shall ensure there are comprehensive risk management procedures in place that, where appropriate, comply with legislation for infection control. Ref: 5.8
	Response by registered person detailing the actions taken: A comprehensive idependent IPC review was undertaken in relation to the the use of the diagnostic room. We have subsequently complied with recommendations outlined in report and the identified risk management procedures. A risk assessment is now in place and this has been shared with staff.

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

The Regulation and Quality Improvement Authority

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

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

Assurance, Challenge and Improvement in Health and Social Care