# COVID-19 Independent Hospital Inspection
# Unannounced Inspection Report
# 08 March 2021

# Hillsborough Private Clinic

**Type of Service: Independent Hospital – Surgical Services**
**Address: Cromlyn House, 2 Main Street, Hillsborough BT26 6AE**

**Tel No: 028 9268 8899**

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

## Membership of the inspection team

| | |
|---|---|
| Carmel McKeegan | Inspector, Independent Health Care Team,<br>Regulation and Quality Improvement Authority |
| Norma Munn | Inspector, Independent Health Care Team,<br>Regulation and Quality Improvement Authority |
| Dr Ian Gillan | Laser Protection Advisor,<br>Regulation and Quality Improvement Authority |
| James Robinson | Junior Medical Physician |
| Phil Cunningham | Senior Inspector, Estates Team,<br>Regulation and Quality Improvement Authority |

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 from their responsibility for maintaining compliance with legislation, standards and best practice.

## 1.0 What we look for


## 2.0 Profile of service

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 surgical day case procedures. There are no overnight beds provided in this service.

## 3.0 Service details

| | |
|---|---|
| **Organisation/Registered Persons:**<br>Mr Gary McKee<br>Mr James Sharkey | **Registered Manager:**<br>Mrs Dianne Shanks |
| **Person in charge at the time of inspection:**<br>Mrs Dianne Shanks | **Date manager registered:**<br>01 May 2007 |
| **Categories of care:**<br>(IH) Independent Hospital<br>AH(DS) - Acute Hospital (Day Surgery)<br>PD - Private Doctor<br>PT (L) - Laser<br>PT (E) – Endoscopy | |

**Laser equipment**

**Manufacturer**: Nidek

**Model**: YC-1800

**Laser Class**: 3B

**Wave Length**: Nd YAG 1064nm

**Serial Number**: Y1650186

**Laser protection advisor (LPA)**: Anna Bass, Lasermet

**Laser protection supervisor (LPS)**: Mrs Dianne Shanks

**Medical support services:** Mr James Sharkey

**Clinical authorised users**: Seven named Consultants Ophthalmologists

**Types of treatment provided**: Refractive eye surgery

## 4.0 Inspection summary

In response to the COVID-19 pandemic we introduced a series of Infection Prevention and Control (IPC) Inspections of Health and Social Care (HSC) Acute and Independent Hospitals across Northern Ireland. This programme of inspections was undertaken following receipt of information by members of the public who were concerned with IPC practices when they visited our hospitals.

We undertook an unannounced inspection to Hillsborough Private Clinic (HPC) on 08 March 2021.

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 (DoH) Minimum Care Standards for Independent Healthcare Establishments (July 2014). The inspection framework also draws on best practice guidance from a range of sources including Public Health Agency Northern Ireland (PHA), DoH Northern Ireland and Public Health England (PHE).

We sought assurances across the following key criteria to determine if each hospital inspected had an effective approach to infection control:

- governance and collaborative working across the hospital;
- risk assessment;
- audits of staff practices;
- staff work patterns;
- staff training;
- environment and cleaning practices;
- innovative practice:
- observations of staff practice;
- information sharing;
- supporting patients and visitors; and
- support for staff.

The Laser Protection Advisor for RQIA reviewed the safety measures in place to manage and maintain the current laser. The findings and laser safety report are appended to this report.

The focus of this inspection was to assess the hospital's arrangements regarding a COVID-19 safe environment. We additionally reviewed areas for improvement stated within the quality improvement plan (QIP) from the previous unannounced inspection on 18 February 2020.

We spoke with Mr Sharkey, Registered Person; Mrs Dianne Shanks, Registered Manager; the Deputy Manager and a range of nursing staff and administration staff as outlined in Section 6.3.11 of this report.

We observed IPC practices and had discussions with staff to determine their knowledge and understanding of the current best practice guidance in relation to IPC.

Our inspection to HPC has highlighted numerous strengths in achieving and maintaining a COVID-19 safe environment. We were assured of robust governance and oversight of measures to prevent the spread of the virus. We found evidence of collaborative and professional working with good communication systems for the sharing of information and learning. We found that overall COVID-19 risk assessments were comprehensively completed for clinical and non-clinical areas and many environmental control measures have been implemented to reduce the risk of transmission of the virus. We were assured that staff have received enhanced IPC training and we found systems were in place for the monitoring of staff practices.

We found that staff had a good understanding of the measures to prevent transmission of the virus and this was further supported in our observations of their practices. We observed effective hand hygiene practices and a good use of personal protective equipment (PPE). In addition we observed staff supporting patients to comply with IPC measures.

We observed an excellent standard of environmental and equipment cleaning and good signage to direct visitors and staff.

No immediate concerns were identified regarding the delivery of front line patient care.

## 4.1 Inspection outcome

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 0 | 0 |

This inspection resulted in no areas for improvement being identified. We discussed the findings of the inspection with Mrs Dianne Shanks, Registered Manager, and the Deputy Manager, as part of the inspection process and can be found in the main body of the report.

This inspection did not result in enforcement action.

## 5.0 How we inspect

Prior to this inspection a range of information relevant to the service was reviewed, including the following records:

- the registration status of the establishment;
- written and verbal communication received since the previous inspection;
- the previous inspection reports;
- the returned QIP from the previous care inspection;
- Serious Adverse Incident notifications;
- information on concerns;
- information on complaints; and
- other relevant intelligence received by RQIA.

During our inspection we assessed both clinical and non-clinical areas using an inspection framework which draws from a range of best practice sources in the management of COVID-19.

We inspected the reception area, waiting areas, consultation rooms, the main theatre and adjoining recovery area, laser treatment room, store rooms, sluice and patient toilet areas.

We examined records in relation to each of the areas inspected, spoke with staff working in each area and observed their IPC practices. We carried out assessments of the physical environment and reviewed the infection control measures implemented to reduce risk of transmission of the virus.

Five areas for improvement identified at the 18 February 2020 inspection were reviewed and an assessment of achievement was recorded as met.

Posters informing patients, staff and visitors of our inspection were displayed while our inspection was in process.

It was agreed with the DoH that where an Independent Hospital provides treatments using endoscopes that the arrangements for the decontamination of endoscopes would be reviewed. Following the inspection HPC were provided with an electronic copy of the Institute Of Healthcare Engineering & Estate Management Joint Advisory Group (on GI Endoscopy) audit tool. The audit is to be completed and returned to Phil Cunningham, Senior Estates Inspector, RQIA within one month of the audit being issued, following which the completed audit will be reviewed and report issued under separate cover. Additional information in this regard can be found in section 6.4.3 of this report.

We invited staff and patients to complete an electronic questionnaire during the inspection. No questionnaires were received by RQIA.

## 6.0 The inspection

## 6.1 Review of areas for improvement from the previous inspections on 18 February 2020

The most recent inspection of HPC was an unannounced multidisciplinary inspection undertaken on the 18 February 2020. The completed QIP was returned and approved by the care inspector.

## 6.2 Review of areas for improvement from the previous inspection on 18 February 2020

| Quality Improvement Plan | | |
|---|---|---|
| **Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Minimum Care Standards for Independent Healthcare Establishments (2014)** | | **Validation of compliance** |
| **Clinical Governance** | | |
| **Area for improvement 1**<br><br>**Ref**: Standard 30.1<br><br>**Stated:** First time | The Registered Persons shall ensure the role of the Medical Advisory Committee (MAC) is formalised with terms of reference provided in accordance with Standard 30.<br><br>The MAC should meet quarterly as a minimum with formal minutes kept and a record of meetings maintained. | |
| | **Action taken as confirmed during the inspection**:<br>We spoke with Mrs Shanks and discussed the organisational governance arrangements. We confirmed that terms of reference had been developed which outlined the role and function of the MAC. Mrs Shanks confirmed the MAC meeting takes place quarterly. We reviewed minutes of the most recent MAC meeting dated | **Met** |

| | | |
|---|---|---|
| | 19 January 2021. We evidenced that the MAC reviewed the outcome of the most recent audits completed in respect of key performance indicators. These included complaints, incidents, post-operative complications, surgical site infections, infection control, review of the COVID-19 risk assessment; staffing provision; and review of outpatient medical records audit. We noted the MAC also reviewed the Consultant's practicing privileges agreements due for renewal and confirmed those agreements which were approved for renewal and those which required further documents/information.. We found the minutes recorded the outcomes of the meeting with a timed action plan detailing who was responsible to action each of the areas identified. | |
| **Medical Governance** | | **Validation of compliance** |
| **Area for improvement 2**<br><br>**Ref**: Standard 9.3<br><br>**Stated:** First time | The Registered Persons shall implement a system of audit/peer review of outpatient's medical records, including those records not stored on site, by someone with the knowledge and skill to identify if there were any concerns. A record of the findings, outcome and learning identified should be retained. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>We confirmed that a system has been implemented to audit outpatient's medical records including those not held on site. We found that an agreed template for auditing of outpatients medical records was used for this purpose. We evidenced that each month an identified medical practitioner's outpatients clinical records were audited with the outcome recorded. We confirmed that the outcome of the audit was shared with the respective medical practitioner and where improvement was required this was recorded as having been discussed with the medical practitioner. We found these audits were also included in the MAC meetings. | |

| Complaints Management | | Validation of compliance |
|---|---|---|
| **Area for improvement 3**<br><br>**Ref:** Standard 7<br><br>**Stated:** First time | The Registered Persons shall ensure that complaint management is revised to ensure the hospital retains full ownership of all complaints received. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>We reviewed the arrangements for the management of complaints. We found the Management of Complaints Policy had been updated and stated that HPC shall retain full ownership of all complaints received. We reviewed records of complaints received since the previous inspection and evidenced that HPC requests a response to the issues of complaint from the involved medical practitioner which HPC then includes in their response to the complainant.<br><br>We found that all complaints received are discussed at the monthly Medical Directors Meetings.<br><br>We also evidenced that an audit of complaints is completed at the end of each two month period and is reviewed at the MAC meetings. We were advised that when a complaint is received, where appropriate, consideration is given by the Medical Directors to inform the respective medical practitioner's Responsible Officer. | |
| **Quality Assurance** | | **Validation of compliance** |
| **Area for Improvement 4**<br><br>**Ref**: Regulation 17.1<br><br>**Stated:** First time | The Registered Persons shall address the following matters with respect to key quality indicators and the audit programme:<br><br>• an audit programme agreed by the MAC should be implemented to drive improvements and assure best practice across the hospital.<br>• develop a set of key quality indicators that are evidenced by the audit programme and shared with the MAC and record the evidence of action taken to address any shortfalls;<br>• when issues are identified an action plan should be developed and embedded into practice to address any shortfalls identified. | |

| | | |
|---|---|---|
| | **Action taken as confirmed during the inspection**:<br><br>We found that the MAC had identified and implemented an audit programme to improve patient care. HPC has developed a core set of key performance indicators which are included in the terms of reference for the MAC. We confirmed that any learning outcomes from completed audits are shared with the relevant staff members. Discussion with Mrs Shanks and staff members indicated they found this process to be effective and that they feel this has contributed to improvement in service provision and delivery. | **Met** |
| **Policy and Best Practice Guidance** | | **Validation of compliance** |
| **Area for Improvement 5**<br><br>**Ref:** Regulation 15 (1) (b)<br><br>**Stated:** First time | The Registered Person shall address the following matters with respect to antimicrobial/antibiotic stewardship:<br><br>• ensure that an anti-microbial/antibiotic stewardship policy is developed in keeping with NICE guideline [NG15];<br>• ensure the MAC and relevant clinicians/clinical groups actively contribute to the development of the policy;<br>• ensure the policy clearly describes the prophylactic medications that may be prescribed by clinicians practising in the hospital; and<br>• ensure that a rolling audit programme is developed to provide assurance that the policy is being adhered to. | |
| | **Action taken as confirmed during the inspection**:<br><br>Mrs Shanks informed us that following the previous inspection an antimicrobial/antibiotic stewardship policy had been drafted and was subsequently ratified by the MAC.<br><br>We reviewed this policy and confirmed that it had been developed in line with the NICE guidelines, as above.<br><br>We confirmed the policy clearly outlines the prophylactic medications that may be prescribed by medical practitioners practising in HPC. We found that antimicrobial stewardship audits had been completed in a | **Met** |

| | | |
|---|---|---|
| | meaningful manner. We noted that the outcome of audits were scrutinised and any areas for improvement were discussed with the relevant medical practitioner. | |
| **Area for Improvement 6**<br><br>**Ref**: Regulation 15 (1) (b)<br><br>**Stated:** First time | The Registered Persons shall address the following matters with respect to the management of venous thromboembolism (VTE):<br><br>• review the current VTE management policy and ensure that it is in keeping with NICE guideline [NG89];<br>• ensure that the MAC and other relevant clinicians contribute to and approves the hospital's updated VTE policy;<br>• ensure that VTE risk assessments are undertaken and documented in respect of all patients admitted for surgical procedures; and<br>• develop a rolling audit programme to provide assurance that the VTE policy is being adhered to. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>We reviewed the VTE Policy and confirmed that policy had been updated in line with the NICE guidelines, as above. The policy document includes the relevant medical practitioners as contributing authors of this document which had been ratified by the MAC in July 2020.<br><br>We reviewed relevant records and evidenced that VTE risk assessments had been completed for all patients undergoing podiatric surgery. We established that adherence to the policy is monitored through a quarterly audit of relevant clinical records and any confirmed cases of VTE would be monitored through the post-operative complications recording system which is also included in the auditing programme. | |

## 6.3 Inspection findings

### 6.3.1 Governance and collaborative working

The COVID-19 pandemic has presented significant challenges in respect of how HPC's care is planned and delivered. Changes that would typically take months or years to come into effect have been agreed and implemented at speed and under huge pressures while ensuring HPC remains a safe environment for patients and staff. Incorporating these changes requires effective governance arrangements, which are underpinned by good business management and the application of clear strategic and organisational objectives.

We sought assurance of effective governance arrangements in the planning and delivery of IPC measures by reviewing key areas of collaborative working; communication systems; COVID-19 risk assessments; the monitoring of staff practices; work patterns and staff training. Staff told us that the management had reviewed and implemented measures to promote a COVID-19 safe environment throughout HPC.

We reviewed a selection of documentation including minutes of meetings; risk assessments; audits of the environment and staff practices; and staff training records. We confirmed good governance measures were in place for the preparation of the hospital in the implementation of a COVID-19 safe environment.

We met with Mrs Shanks, Registered Manager, who is responsible for the safety, health and wellbeing of staff and patients during the COVID-19 pandemic. Mrs Shanks is supported by an IPC lead nurse within the hospital and also an external IPC advisor who works in a HSC Trust. We were told that a collaborative approach ensured efficiency and consistency in the implementation of IPC measures throughout the hospital to promote a safer workplace.

We found evidence of information sharing and minutes of meetings confirming collaborative working between all disciplines and clear pathways of information flow through different levels of management. Staff told us how they worked collaboratively, to identify risks and implement risk reducing measures in all clinical and non-clinical areas. Staff were complimentary of the support provided by Mrs Shanks and the IPC lead nurse.

We found effective governance arrangements underpinned by clear strategic and organisational objectives aimed at preventing the spread of the virus. We found evidence of collaborative and multi professional working and good communication systems for the sharing of information and learning.

### 6.3.2 COVID-19 risk assessments

There was evidence of collaborative work between HPC's management team, clinical staff and the IPC lead nurse in the development of the COVID-19 environmental risk assessments. The risk assessments are used to support staff to recognise and manage the COVID-19 infection risk. Staff told us that risk assessments were undertaken to include all areas of the hospital. We heard how control measures were continuously being reviewed and updated to optimise solutions.

We reviewed the COVID-19 general risk assessment for HPC which included clinical and non-clinical areas, theatre/recovery area, waiting rooms and reception area and we were assured that the hospital had robust measures in place to protect patients and staff.

### 6.3.3 Sharing of information

Staff informed us that they have access to up to date policies and procedures, and were provided with updates in a number of different ways including by email, staff handovers and staff meetings.

Information and posters were also displayed for staff and staff were aware of the procedures to be followed if they became unwell.

In the hospital, we found clear lines of communication such as emails and posters to provide staff with the latest updates on COVID-19. Additionally, the hospital provided posters and information which were displayed on notice boards in the waiting room to provide the latest updates to the public.

### 6.3.4 Auditing of staff practices

We reviewed a range of audits undertaken in clinical areas including, environmental and hand hygiene audits which confirmed good compliance. We also reviewed evidence of the actions which had been taken to address areas requiring improvement, where necessary.

Mrs Shanks and the IPC lead nurse complete audits of clinical practices and environmental audits. We reviewed a selection of these audit tools which identified areas of good practice and areas for improvement.

We were satisfied that the hospital has robust measures in place to monitor staff practices.

### 6.3.5 Staff work patterns

We were told of the measures taken to enable social distancing with the establishment. All staff have been involved in ensuring a limited number of patients are in attendance at any given time. Appointment planning has been reviewed with additional protected time built in to facilitate enhanced cleaning regimes between patient appointments and treatments. The change in appointment timings has resulted in increased working in the evenings and at weekends. We were informed that all staff have been very flexible in their availability to ensure patient appointments are provided and that there are appropriately skilled and experienced staff in place at any given time to meet the needs of the patients.

### 6.3.6 Staff training

We reviewed training records for staff in relation to IPC and found that mandatory IPC training was up to date. Additional training for staff in relation to COVID-19 has been facilitated by the Belfast Health and Social Care Trust.

When we spoke with staff they confirmed that they had received training on IPC and COVID-19 and were knowledgeable in relation to IPC practices in line with best practice guidance.

### 6.3.7 Environment and cleaning practices

The standard of environmental cleaning throughout the hospital was excellent. Non-clinical areas such as the reception area and consultation rooms were clean, tidy and uncluttered. We offered advice in relation to further decluttering the ground floor waiting room and toilet areas and were given assurances that any issues discussed would be addressed.

At the entrance and reception area of the hospital there was clear signage in place to remind visitors of the COVID-19 restrictions and the need for hand hygiene. Communal areas were all clearly identified with posters and floor markings highlighting social distancing measures and IPC guidance.

We observed that chairs were positioned in waiting areas to facilitate social distancing and posters displayed to direct staff and patients in the correct IPC precautions to be taken.

Cleaning schedules were in place and equipment was clearly identified as having been cleaned. We were assured that all necessary environmental steps had been taken to reduce the risk of infection throughout the hospital.

We concluded that environmental cleanliness was of a high standard and the environment was well maintained.

### 6.3.8 Innovative practice

We observed that the staff changing area was compact and facilitated only one member of staff at a time. We were advised that an alternative area was being created for staff that will provide a larger changing area,showering and toilet facilities, and be able to facilitate individual staff lockers. The new staff facility will be located in separate premises at the rear of HPC. We were informed that these premises are owned by HPC and are for staff use only. We discussed the potential registration requirement in this regard which will be followed up under separate cover following this inspection.

### 6.3.9 Observations of staff IPC practices

We spoke to a range of staff in all areas of the hospital and found them to be knowledgeable on IPC practices. Observations of staff IPC practices in both clinical and non-clinical areas when undertaking hand hygiene practices, using PPE and environmental and equipment cleaning supported this finding. Staff were observed to undertake opportunities for hand hygiene at appropriate times in line with the hospital's policy and best practice guidance. We observed staff were compliant with the dress code policy. Overall, PPE was accessible and worn appropriately in line with current guidance. Additionally, in line with COVID-19 guidance, we observed staff adhering to social distancing and wearing face masks in non-clinical areas such as the consulting rooms, corridors and reception area.

We reviewed cleaning schedules and checked items of patient equipment in the theatre and recovery area and found them to be clean and fit for purpose. The management of sharps and segregation of waste was in line with the hospital's policy.

Social distancing by staff and patients was well adhered to in both clinical and non-clinical areas. We discussed the mechanisms in place with staff to challenge non-adherence when social distancing measures were breached. All staff questioned stated they would be happy to challenge anyone not compliant with any aspect of COVID-19 precautions. All staff confirmed that they would be happy to escalate concerns through line management structures.

### 6.3.10 Patient and visitor support

We invited patients to complete an electronic questionnaire during the inspection. No patient questionnaires were received by RQIA during or following the inspection.

Due to social distancing practices and limited patient numbers in the hospital we did not have an opportunity to speak to patients/visitors during this inspection. We were informed visitors were not permitted unless for compassionate reasons and where appropriate arrangements would be discussed and agreed with the hospital prior to attending a pre-planned appointment.

### 6.3.11 Support for staff

We spoke with the following members of staff, where social distancing measures could be maintained, including Mr Sharkey, one of the Registered Persons and Mrs Shanks, Registered Manager.

- Deputy Manager;
- Lead IPC Nurse;
- Theatre Nurse;
- Recovery Nurse;
- Staff Nurse;
- Receptionist; and
- Health Care Assistant.

We found staff at all levels to be helpful and supportive throughout the inspection.

Staff told us of the anxiety they experienced at the start of the pandemic. Staff informed us they have received good support from Mr McKee and Mr Sharkey; Mrs Shanks; the IPC Lead Nurse; and from each other. Staff reported being proud of the good team work throughout the hospital and they appreciated the peer support during the pandemic.

We invited staff to complete an electronic questionnaire during the inspection. No staff questionnaires were received by RQIA following the inspection.

## 6.4 Additional areas examined

### 6.4.1 Laser safety

We reviewed the arrangements in respect of the safe use of the laser equipment in HPC and found a laser safety file was in place that contained all of the relevant information.

We found there was written confirmation of the appointment and duties of a certified Laser Protection Advisor (LPA). We reviewed the service level agreement between HPC and their LPA and found this to be a satisfactory arrangement.

We established that named Consultants, in accordance with medical treatment protocols, carry out Capsulotomy and Iridectomy refractive eye procedures using the laser equipment. We found a system was in place to review the medical treatment protocols on an annual basis. We identified the LPA's report from 2019 included an action point to ensure that the available protocols referred to Iridectomy in addition to Capsulotomy. Although the protocols had since been updated this action had not been clearly addressed. We discussed this matter with Mr Sharkey, author of the medical treatment protocols, who stated that the protocols would be clarified in this regard.

We found the Local Rules, developed by the LPA, contained relevant information pertaining to the laser equipment being used and these had been signed by the seven named Consultants and other staff involved in laser procedures.

Staff training records were available for all seven authorised operators in relation to laser safety, core of knowledge and applications training for the specific laser system. We observed a robust process was in place to monitor training and ensure compliance in this area.

We found safe and effective arrangements in place for the use of laser equipment including controlled access to the environment; displaying of laser safety warning signs; controlled access to the laser operating key; clear identification of the authorised Laser Protection Supervisor (LPS) and arrangements for deputisation; maintenance of equipment; and servicing. We established that protective eyewear was available as outlined in the Local Rules.

We observed the Laser Incident Grab Sheet displayed on the wall of the laser treatment room referred to the previous LPA. We were informed that the Incident Grab Sheet would be updated to provide the current LPA's contact details.

We reviewed the laser surgical register which is completed every time the equipment is operated and evidenced that it included the following information:

- the name of the person treated;
- the date;
- the operator;
- the treatment given;
- the precise exposure; and
- any accident or adverse incident.

At the end of each treatment, a record was made in the laser register of the frequency and single pulse energy settings displayed on the laser control panel. We were satisfied the total energy delivered during each treatment session had been consistently recorded.

### 6.4.2 Regulation 26 unannounced quality monitoring visits

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 is not in day to day management of the hospital, unannounced quality monitoring visits must be undertaken and documented every six months.

At our previous inspection on 18 February 2020 we established that Mr McKee and Mr Sharkey both visit HPC on a weekly basis however neither are in day to day management of the establishment. We had advised that an unannounced monitoring visit should be undertaken at least every six months in accordance with legislation with a report retained. During this inspection we discussed this with Mrs Shanks who advised that the unannounced monitoring visits had not yet commenced. Mrs Shanks told us that due to the impact of COVID-19, HPC had closed for a period of time and upon re-opening other areas had to take priority. RQIA were assured that unannounced quality monitoring visits undertaken by the Responsible Individuals or someone delegated on their behalf will commence within the next few weeks.

## 6.4.3 Decontamination of endoscopes

We found arrangements were in place to ensure the decontamination of equipment and reusable medical devices in line with manufacturer's instructions and current best practice. Flexible cystoscopes and reusable medical instruments are decontaminated within a Health and Social Care Central Sterile Services Department (CSSD). Staff who spoke with us advised that single use equipment is used where possible.

As discussed in section 4.0 of this report in response to the COVID-19 pandemic we introduced a series of IPC inspections of Health and Social Care (HSC) Acute and Independent Hospitals across Northern Ireland. It was agreed with representatives at the DoH that these IPC inspections would include a review of the decontamination of endoscopes where applicable.

Following this inspection HPC was provided with an electronic copy of the Institute Of Healthcare Engineering & Estate Management Joint Advisory Group (on GI Endoscopy) audit tool. The audit is to be completed and returned to Phil Cunningham, Senior Estates Inspector, RQIA within an agreed timescale, following which the completed audit will be reviewed and report issued under separate cover.

## 7.0 Quality improvement plan

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

8th March 2021

Ms Carmel McKeegan

Regulation & Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Dear Ms McKeegan

**Laser Protection Report**

Hillsborough Private Clinic
2 Main Street
Hillsborough
BT28 6EA

**Introduction**

Further to the inspection visit to the above premises earlier today this report summarises the main laser protection aspects where improvement may be required. The findings are based on the requirements of current legislation, relevant guidance notes and European Standards.

**Comments**

Treatment Protocol

Lasermet's report from 2019 includes an action point to ensure that the available protocol refers to Iridectomy in addition to Capsulotomy. Although the protocol has since been updated this action has not been clearly addressed
RQIA should be informed when the above matter has been rectified.

**Dr Ian Gillan**
**Laser Protection Adviser to RQIA**

**Appendix 1**

*Hillsborough Private Clinic*
*2 Main Street*
*Hillsborough*
*BT28 6EA*

**Lasers**
Room 2
Manufacturer: Nidek
Model: YC-1800
Class: 3B
Wavelength: Nd YAG 1064nm
Serial no: Y1650186

**Laser Protection Adviser**

Anna Bass, Lasermet

The Regulation and Quality Improvement Authority

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

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