Announced Care Inspection Report
06 February 2018

Hillsborough Private Clinic

Type of Service: Independent Hospital – Surgical Services
Address: Cromlyn House, 2 Main Street, Hillsborough, BT26 6AE
Tel No: 028 92 688899
Inspector: Carmel McKeegan

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

This is a registered independent hospital providing elective day surgery, prescribed technologies in the form of endoscopy procedures and private doctor services.

The establishment is also registered to provide laser treatments however the registered manager had informed RQIA on 6 November 2017 that the service is suspended as the only registered authorised operator had retired. There are no overnight beds provided in this service.

3.0 Service details

Organisation/Registered Provider: Hillsborough Private Clinic **Responsible Individuals:** Mr Gary McKee, Mr James Sharkey	**Registered Manager:** Mrs Dianne Shanks
Person in charge at the time of inspection: Mrs Dianne Shanks	**Date manager registered:** 01 May 2007
Categories of care: Acute Hospital (Day Surgery) AH(DS) Prescribed Technologies, Endoscopy PT(E) Prescribed Technologies, Laser PT(L) Private Doctor PD	**Number of registered places:** 0

4.0 Inspection summary

An announced inspection took place on 06 February 2018 from 10.00 to 15.45.

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).

The inspection assessed progress with any areas for improvement identified since the last care inspection and to determine if the establishment was delivering safe, effective and compassionate care and if the service was well led.

Areas of good practice were identified in relation to patient safety in respect of recruitment; safeguarding; the provision of surgical services; resuscitation arrangements, infection prevention and control and decontamination arrangements and the management of medical emergencies; and the environment. Other examples included: the management of the patients' care pathway; communication; records management, practising privileges arrangements and engagement to enhance the patients' experience.

One area of improvement against the regulations was identified during the inspection to provide all staff with training in dementia care.

No patients were available for discussion during the inspection. Patients who submitted questionnaire responses indicated a high level of satisfaction with the care and services provided.

The following comments were provided in the submitted questionnaire responses:

- "Really great service, Very helpful efficient and friendly made procedures so much easier"
- "Excellent care at Hillsborough."
- "The staff were courteous and kind at all times and made me feel very welcome."
- "All members of staff treated me with courtesy, dignity and patience."

The findings of this report will provide the establishment with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	0

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Diane Shanks, registered 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.

4.2 Action/enforcement taken following the most recent care inspection dated 25 July 2016

No further actions were required to be taken following the most recent inspection on 25 July 2016

5.0 How we inspect

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

- notifiable events since the previous care inspection
- the registration status of the establishment
- written and verbal communication received since the previous care inspection
- the previous care inspection report
- submitted complaints declaration

Questionnaires were provided to patients prior to the inspection by the practice on behalf of RQIA. Returned completed patient questionnaires were also analysed prior to the inspection

A poster in relation to staff questionnaires had been provided to the practice prior to the inspection advising staff of the opportunity to complete an electronic questionnaire. However no questionnaires had been received by RQIA. It is acknowledged that some difficulties have been

experienced with the introduction of electronic questionnaires and RQIA continues to work to resolve the matter.

During the inspection the inspector met with Mrs Shanks, registered manager, two registered nurses, including the deputy manager and an administrator. A tour of the premises was also undertaken.

A sample of records were examined during the inspection in relation to the following areas:

- staffing
- recruitment and selection
- surgical services
- 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

The findings of the inspection were provided to Mrs Shanks, registered manager, at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 21 August 2017

The most recent inspection of the establishment was an announced medicines inspection and there were no areas for improvement identified at this inspection.

6.2 Review of areas for improvement from the last care inspection dated 25 July 2016

There were no areas for improvement made as a result of the last care inspection.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Staffing

A review of duty rotas, discussion with staff and completed 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, anaesthetists, nurses, nursing auxiliaries and administrators with specialist skills and experience to provide a range of hospital services including surgical services. Discussion with Mrs Shanks confirmed that the theatre and outpatient clinic lists are reviewed and staff rostered accordingly to meet the needs of the patients. A number of bank/relief nurses who have relevant experience are available to ensure adequate staffing levels are provided.

Induction programmes templates were in place relevant to specific roles within the hospital. A sample of one evidenced that an induction programme is completed when new staff join the establishment.

Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place. Staff felt supported and involved in discussions about their personal development. Review of a sample of three evidenced that appraisals had 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. The hospital affords staff opportunities to undertake specialist qualifications and a five year study plan is in place.

As a result of a recent event that occurred within the hospital it was identified that all staff should complete training in caring for the patient with dementia. A discussion took place in relation to the provision of training in dementia care and an area of improvement against the regulations was made in this regard.

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.

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 arrangements were in place to ensure they provide evidence they have received the required annual appraisals.

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

Six 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

Mrs Shanks has written to medical practitioners who are required to provide up to date information. If it is not provided by the specified timescale Mrs Shanks confirmed the matter will be forwarded to the medical directors for action.

Each medical practitioner has an appointed responsible officer.

Recruitment and selection

Mrs Shanks confirmed that one new staff member had been recruited since the previous inspection. A review of the staff member's personnel file demonstrated that all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained.

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 Mrs Shanks or deputy manager, the surgeon and administrative staff. 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 used.

Review of the patient care records and discussion with staff confirmed that the anaesthetist who administers the anaesthetic visits the patient prior to surgery in order 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 Mrs Shanks and staff confirmed that the surgeon meets 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 the 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 safety 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.

Discussion with staff 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 provides day surgery only and has discharge criteria in place from recovery to the waiting area if necessary or home.

A review of the 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

As previously stated the registered manager had informed RQIA on 6 November 2017 that the service is temporarily suspended as the previously only registered authorised operator had retired. Mrs Shanks confirmed that there are no immediate plans to resume laser refractive eye surgery.

There was no laser equipment on site to inspect and it was confirmed that the laser protection advisor (LPA) had been informed of the temporary suspension of this service. Ms Shanks, registered manager and radiation protection supervisor, confirmed that, in the future, should a decision be made to resume laser treatment, RQIA and the LPA would be notified and arrangements made for the necessary documentation and risk assessments to be completed and in place, prior to laser treatment being provided.

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.

It was confirmed that copies of the regional policy entitled ‘Co-operating to Safeguard Children and Young People in Northern Ireland’ issued during March 2016 and the regional guidance document entitled ‘Adult Safeguarding Prevention and Protection in Partnership’ issued during July 2015 were both available for staff reference.

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 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

Mrs Shanks confirmed an emergency GI (gastro-intestinal) bleed kit is also available in theatre during specific endoscopy procedures.

A review of training records and discussion with staff confirmed that staff have undertaken basic life support training and updates. Permanent nursing staff had also received advanced life support training and updates. There is always at least one staff member with advanced life support training on duty at all times.

Staff involved in the provision of paediatric care have paediatric life support training and updates.

Staff confirmed periodic resuscitation drills have been carried out.

Mrs Shanks confirmed the arrangements regarding patients with a "Do Not Resuscitate" (DNR) order in place. 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.

A resuscitation policy was in place and reflected best practice guidance. Advice was given on the provision of protocols for managing medical emergencies for staff reference outlining the local procedure for dealing with various medical emergencies.

Infection prevention control and decontamination procedures

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

Mrs Shanks confirmed the hospital has access to an external infection prevention and control advisor.

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. The hospital has a contract in place with the CSSD (Central Sterile Services Department) of the Ulster Hospital. The decontamination of endoscopes is carried out off site at the Belfast City Hospital.
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

Staff confirmed the results of these audits are discussed at team meetings. The compliance rate was noted to be very high and an action plan was in place for areas of non-compliance.

A risk assessment for infective diarrhoea was noted to be carried out for patients as part of the admission process.

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

A review of IPC arrangements indicated that very good infection control practices are embedded in the hospital. There were a range of IPC policies and procedures in place which were located within an IPC manual.

Environment

The environment was maintained to a fair standard of maintenance and décor. Since the previous inspection a redecoration programme has been completed which included replacing carpeted flooring in the consultation rooms and repainting walls. The stair lift had been upgraded to facilitate easier access for patients with a disability.

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 Shanks demonstrated that arrangements are in place for maintaining the environment.

A legionella risk assessment was last undertaken on 22 March 2016 and an action plan was in place.

The maintenance of equipment arrangements was reviewed and found to be robust.

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

Fourteen patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm and indicated a high level of satisfaction with this aspect of care.

No staff questionnaire responses were received.

Areas of good practice

There were examples of good practice found in relation to staff recruitment, induction, supervision and appraisal, safeguarding, management of medical emergencies, infection prevention control and decontamination procedures and the environment.

Areas for improvement

Dementia training should be completed by all staff.

	Regulations	Standards
Total number of areas for improvement	1	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

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.

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

- patient personal information
- holistic assessments
- venous thromboembolism (VTE) risk assessment (foot surgery patients)
- pre-operative care plans
- pre-operative checks
- signed consent forms
- surgical safety checklist
- operation notes
- anaesthetic notes
- medical notes
- intra-operative care plans
- post-operative care plans
- discharge plan

Staff confirmed that patients receive 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.

Records

Systems were in place to audit the patient care records as outlined in the establishments quality assurance programme.

Mrs Shanks confirmed components of the care pathway are audited and review of the audits found that they have led to improvements.

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

The establishment is registered with the Information Commissioner's Office (ICO).

Discussion with staff confirmed they had a good knowledge of effective records management.

The establishment 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 establishment 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 are well developed discharge planning arrangements in place that require full engagement with patients and/or their representatives.

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

All of the patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them and indicated a high level of satisfaction with this aspect of care.

No staff questionnaire responses were received.

Areas of good practice

There were examples of good practice found in relation to the patient care pathway and discharge planning.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Dignity, respect and rights

Discussion with Mrs Shanks and staff regarding the consultation and treatment process confirmed that patient's modesty and dignity is respected at all times. Day patients and outpatients are provided with modesty screens and curtains as appropriate.

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 staff and review of seven 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 in the administration office.

Staff were observed treating patients and/or their relatives/representatives with compassion, dignity and respect.

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

Review of patient care records and discussion with 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 2003.

The hospital retains a copy of these guidelines and this is accessible to staff.

Staff confirmed that bad news is delivered to patients and/or their representatives by professionals 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 hospital obtains the views of patients and/or their representatives on a formal and informal basis as an integral part of the service they deliver.

Patients are offered the opportunity to complete a satisfaction questionnaire within the hospital. A review of a random selection of completed questionnaires found that patients were highly satisfied with the quality of treatment, information and care received. Comments received on the feedback questionnaires included:

- "I cannot speak highly enough of staff."
- "Well looked after and cared for before and after surgery."
- "The outcome is amazing, I felt quite at ease."
- "Second to none, from consultants to nursing staff."

The information received from the patient feedback questionnaires is collated into an annual summary report which is made available to patients and other interested parties to read within the establishment.

Discussion with Mrs Shanks confirmed that comments received from patients and/or their representatives are reviewed by senior management within the establishment 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

All of the patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care and indicated a high level of satisfaction with this aspect of care.

No staff questionnaire responses were received.

Areas of good practice

There were examples of good practice found in relation to maintaining patient confidentiality, ensuring the core values of privacy and dignity were upheld, providing the relevant information to allow patients to make informed choices.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

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 Shanks is the nominated individual with overall responsibility for the day to day management of the hospital.

The registered providers are medical practitioners who provide medical services in the hospital and act as medical directors for the hospital.

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 clinical governance committee involving all areas of the hospital service.

Hillsborough Private Clinic has devised a Quality Improvement Plan for 2017 setting out the improvements and targets for 2017 to be achieved through robust audit. A detailed Risk Management Strategy has been implemented in the hospital.

Staff confirmed there are monthly staff meetings and these are held more regularly if necessary. Mrs Shanks has a meeting with the medical directors on a monthly basis and confirmed she can contact them at any time. Minutes of meetings were reviewed.

Policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, dated and systematically reviewed on a three yearly basis. 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 displayed in the hospital. 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 indicated that complaints have been managed in accordance with best practice.

Mrs Shanks 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. A sample of audits was examined, including:

- environmental
- accidents and incident
- hand hygiene
- infection prevention and control
- venous thromboembolism (VTE)
- controlled drugs
- IV insertion
- laser patients
- hypothermia in theatre
- surgical safety checklist
- consent form

A system was in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies as appropriate. A recent event which had been reported to RQIA was discussed with Mrs Shanks and will be followed up under separate cover. However in the

interim, it has been identified that all staff should complete training in caring for the patient with dementia. As previously stated an area of improvement has been made against the regulations that all staff undertake training in this regard.

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 Shanks outlined the process for granting practising privileges and confirmed medical practitioners meet with her prior to privileges being granted and the medical directors' grant practising privileges.

Six 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. It was advised that one of the medical directors should also countersign the agreement. Mrs Shanks confirmed this would be undertaken immediately by one of the medical directors.

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

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

A whistleblowing/raising concerns policy was available. Discussion with staff confirmed that they were aware of who to contact if they had a concern.

Mrs Shanks demonstrated a very clear understanding of her 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.

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

All of the patients who submitted questionnaire responses indicated that they felt that the service is well led and indicated a high level of satisfaction with this aspect of the service.

No staff questionnaire responses were received.

Areas of good practice

There were examples of good practice ins relation to the management of complaints and incidents and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Diane Shanks, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 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 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).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan	
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 18 (2) (a) **Stated:** First time **To be completed by:**	The registered person shall ensure that all staff undertakes training in caring for the patient with dementia. Ref: 6.4
	Response by registered person detailing the actions taken: 2 members of staff have had dementia training. A training date of 12th May has been arranged for all other staff.

30 April 2018	

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

The Regulation and Quality Improvement Authority

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