Announced Care Inspection Report
25 July 2016

Hillsborough Private Clinic

Type of Service: Independent Hospital – surgical services
Address: Cromlyn House, 2 Main Street, Hillsborough, BT26 6AE
Tel No: 02892688899
Inspector: Winnie Maguire

1.0 Summary

An announced inspection of Hillsborough Private Clinic took place on 25 July 2016 from 10:00 to 16:45.

The inspection was to determine if the service was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Observations made, review of documentation and discussion with Mrs Dianne Shanks, Registered Manager, and staff demonstrated that systems and processes were in place to ensure that care to patients was safe and avoids and prevents harm. Areas reviewed included staffing, recruitment and selection, surgical services, laser safety, safeguarding, resuscitation and management of medical emergencies, infection prevention control and decontamination, and the general environment. Advice was given on the storage of AccessNI information and the further development of the resuscitation policy to include specific protocols. No requirements or recommendations have been made.

Is care effective?

Observations made, review of documentation and discussion with Mrs Shanks and staff demonstrated that systems and processes were in place to ensure that care provided in the establishment was effective. Areas reviewed included the care pathway, clinical records, patient information and decision making and discharge planning. Advice was given on the expansion of the care pathway audit. No requirements or recommendations have been made.

Is care compassionate?

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

Is the service well led?

Information gathered during the inspection evidenced that there was effective leadership and governance arrangements in place which creates a culture focused on the needs of patients in order to deliver safe, effective and compassionate care. Areas reviewed included organisational and staff working arrangements, the arrangements for policy and risk assessment reviews, the arrangements for dealing with complaints, incidents and alerts, insurance arrangements, the arrangements for managing practising privileges and the registered person's understanding of their role and responsibility in accordance with legislation. Hillsborough Private Clinic has devised a Quality Improvement Plan for 2016 setting out the improvements and targets for 2016 to be achieved through robust audit. A detailed Risk Management Strategy has been implemented in the hospital. No requirements or recommendations have been made.

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

1.1 Inspection outcome

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

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs Dianne Shanks, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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

1.2 Actions/enforcement taken following the most recent care inspection

There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: Mr Gary McKee Mr James Sharkey	**Registered manager:** Mrs Dianne Shanks
Person in charge of the service at the time of inspection: Mrs Dianne Shanks	**Date manager registered:** 1 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:** Not applicable

Laser Equipment

Manufacturer:	Wavelight Laser Technologie AG
Model:	Excimer Allegretto
Serial Number:	1015-1-158
Laser Class:	4
Wavelength:	193nm

Laser Protection Advisor (LPA) – Mr Philp Loan

Laser Protection Supervisor (LPS) – Mrs Dianne Shanks

Medical Support Services – Dr David Frazer

Clinical Authorised User – Dr David Frazer

Types of Treatment Provided – refractive laser eye surgery

3.0 Methods/processes

Questionnaires were provided to patients and staff prior to the inspection by the hospital on behalf of the RQIA. Prior to inspection we analysed the following records: notification of reportable incidents, complaints declaration and returned completed patient and staff questionnaires.

During the inspection the inspector met with Mrs Dianne Shanks, Registered Manager, two registered nurses including the deputy manager, a nursing auxiliary and a member of the administrative team. A tour of the premises was also undertaken.

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

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 20 November 2015

The most recent inspection of the establishment was an announced medicines management inspection. No requirements or recommendations were made during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 29 July 2015

No requirements or recommendations were made during this inspection.

4.3 Is care safe?

Staffing

A review of duty rotas, discussion with staff and completed staff and patient questionnaires demonstrated that there was sufficient staff in various roles to fulfil the needs of the hospital and patients. There is a multi-professional team which includes consultant surgeons, anaesthetists, nurses, nursing auxiliaries and administrators with specialist skills and experience to provide a range of hospital services including surgical services.

No new staff have been recruited since the previous care inspection, however, induction programme templates were in place relevant to specific roles within the hospital.

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.

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.

The hospital affords staff opportunities to undertake specialist qualifications and a five year study plan is in place.

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 no new staff have been recruited since the previous inspection. Should staff be recruited in the future robust systems and processes have been developed to ensure that all recruitment documentation as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 is sought and retained for inspection.

There was a recruitment policy and procedure available. The policy was comprehensive and reflected best practice guidance. Advice was given on the storage of AccessNI checks.

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.

The guidance on the regional labelling of invasive lines and tubes was discussed and it was recommended to devise a local policy in accordance with the regional guidance. However, following the inspection Mrs Shanks was contacted by RQIA to advise her that further information on the matter had been issued by Department of Health and would be distributed to relevant registered services in due course. The recommendation made on the day of inspection was receded in light of the new information from the department and Mrs Shanks agreed to action the matter in accordance to departmental guidance when available.

Laser safety

The hospital provides laser refractive eye surgery. A laser is brought into the hospital on lease approximately once a month for two days under the direct supervision of a qualified laser engineer who oversees the installation of the laser.

A laser safety file is in place which contains all of the relevant information in relation to laser equipment.

There was written confirmation of the appointment and duties of a certified laser protection advisor (LPA) which is reviewed on an annual basis. The service level agreement between the establishment and the LPA was reviewed and this expires on 31March 2017.

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

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

The establishment's LPA updated a risk assessment in relation to the use of the laser on 19 November 2015 and no recommendations were made.

A list of clinical and non-clinical authorised users is maintained and authorised users have signed to state that they have read and understood the local rules and medical treatment protocols.

When the laser equipment is in use, the safety of all persons in the controlled area is the responsibility of the laser protection supervisor (LPS).

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

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

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

Protective eyewear is available as outlined in the local rules for laser technicians/surgical assistants if required (provided when the laser is on site).

The establishment has a laser surgical register which is completed every time the equipment is operated and includes:

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

A review of the laser surgical register during the inspection found it to be comprehensively completed.

There are arrangements in place to service and maintain the laser equipment in accordance with the manufacturer's guidance. The most recent service report dated 18 May 2016 was reviewed as part of the inspection process.

A laser safety file was in place which contained all of the relevant information in relation to laser.

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. The policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The relevant contact details for onward referral to the local Health and Social Care Trust should a safeguarding issue arise were included.

Resuscitation and management of medical emergencies

A review of medical emergency arrangements evidenced that emergency medicines were provided in keeping with the British National Formulary (BNF), and that emergency equipment as recommended by the Resuscitation Council (UK) guidelines 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 infection prevention and control 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. Mrs Shanks advised a redecoration programme was planned in the coming months which would include replacing carpeted flooring in the consultation rooms and repainting walls.

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 22 March 2016 and an action plan was in place.

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

Two patients submitted questionnaire responses to RQIA. Both indicated that they felt safe and protected from harm. Comments provided included the following:

- "Felt very safe with very experienced staff"

Ten staff submitted questionnaire responses. All indicated that they felt that patients are safe and protected from harm. Staff spoken with during the inspection concurred with this. Comments provided included the following:

- "All staff training up to date and computerised option to do extra training, courses available. Premises are clean and areas kept clear for patients and staff safety."
- "Administration staff are included alongside nurses which allows us to ask questions that mightn't come up if just nurses in attendance also gives better insight to admin staff when performing demonstration in first aid."

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.4 Is care effective?

Care pathway

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

Seven 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. It was suggested to carry out a completion of the care pathway audit to further enhance the audits in place.

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

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

Ten submitted staff questionnaire responses indicated that they felt that patients get the right care, at the right time and with the best outcome for them. Staff spoken with during the inspection concurred with this. Comments provided included the following:

- "Record keeping is up to date and concise. Patients are seen on time and kept informed throughout their time in the clinic. Satisfaction surveys are carried out."
- "Has always been stressed patient's care is paramount. If a patient phones into the clinic particularly after surgery, the aftercare is excellent, will always get speaking to a nurse who will contact a consultant if necessary and the patient is phoned back with a response and reassurance."

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.5 Is care compassionate?

Dignity, respect and rights

Discussion with 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.

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

Staff confirmed that bad news is delivered to patients and/or their representatives by 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 30 completed questionnaires found that patients were highly satisfied with the quality of treatment, information and care received. Comments received on the feedback questionnaires included:

- "All care is excellent."
- "Kind and lovely receptionist and medical staff."
- "Professional service."
- "Everything first class."
- "Was made to feel confident that the procedure would be carried out to the highest standard."
- "Wonderful, trouble free and pain free experience."
- "Getting through on the phone is a nightmare."

Mrs Shanks confirmed the action taken as a result of the above patient comment in relation to difficulty getting through on the phone.

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

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

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

- "Following patient satisfaction survey outcomes, patients regularly mark on comment that a first class service was received and with recommendation of telling others of care received."
- "All patients are treated with a high standard of care and compassion and feedback is positive."

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

Management and governance arrangements

There was a clear organisational structure within the hospital and staff were able to describe their roles and responsibilities and were aware of who to speak to if they had a concern. Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. There was a 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 2016 setting out the improvements and targets for 2016 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 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 also countersigns 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

Both patients who submitted questionnaire responses indicated that they felt that the service is well managed. No written comments were provided

Ten submitted staff questionnaire responses indicated that they felt that the service is well led. Staff spoken with during the inspection concurred with this. Comments provided included the following:

- "Dianne is excellent in communicating information whether through staff meetings or one to one basis. Extremely approachable, will always find time to help and solve any problems. I've had many managers whilst previously working in NHS but Dianne is head and shoulders above them all. Top person."
- "All staff are friendly and approachable. Staff meetings are regular to update staff of any changes."

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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

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