Unannounced Inspection Report
22, 23 & 24 January 2019

Ulster Independent Clinic

Type of Service: Independent Hospital – Acute Hospital
Address: 245 Stranmillis Road, Belfast BT9 5JH
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Membership of the Inspection Team

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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 the hospital

The Ulster Independent Clinic provides a wide range of surgical, medical and outpatient services for both adults and children. The hospital is registered to accommodate up to 70 patients as in-patients or day surgery cases.

The hospital has five theatres along with recovery units; a dedicated endoscopy suite; a one stop breast care clinic; a limited chemotherapy service; an x-ray department and magnetic resonance imaging (MRI) scanning; a pathology laboratory; and a range of consulting rooms. The in-patient and day surgery accommodation comprises single en-suite rooms which are situated over two floors.

3.0 Service details

Organisation/Registered Provider: Ulster Independent Clinic **Responsible Individual:** Ms Diane Graham	**Registered Manager:** Ms Diane Graham
Person in charge at the time of inspection: Ms Diane Graham	**Date manager registered:** 11 April 2007
Categories of care: Independent Hospital (IH): Acute hospital (with overnight beds) AH Acute Hospital (Day Surgery) AH (DS) Private Doctor PD Prescribed Technologies: Endoscopy PT (E) Laser PT (L)	**Number of registered places:** 70

Laser equipment (located in theatre five)

Manufacturer: Cook Medical

Model: H30 Holmium laser system

Serial Number: LHT65630416

Laser Class: 4

Laser protection advisor (LPA): Philip Loan

Laser protection supervisor (LPS): Sister Katherine Stanley

Clinical authorised users: Six named Consultant Urologists

Types of treatment provided: Laser fragmentation of ureteric stones

4.0 Inspection summary

We undertook an unannounced inspection to the Ulster Independent Clinic (UIC), over three days, commencing on Tuesday 22 January 2019 and concluding on Thursday 24 January 2019.

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).

We employed a multidisciplinary inspection methodology during this inspection. RQIA's Medical Physics Expert supported the inspection in respect of the laser operated within the hospital. Two Health Estate Engineers from the Department of Health (DoH) supported the inspection of UIC's endoscopy suites and arrangements for reprocessing of flexible endoscopes; this was prompted by an application from UIC to vary their registration to include a new dedicated endoscopy suite.

Our multidisciplinary inspection team examined a number of aspects of the hospital, from front-line care and practices, to management and oversight of governance across the organisation. We met with various staff groups, spoke with several patients, observed care practice and reviewed relevant records and documentation used to support the governance and assurance systems.

Patients and their representatives advised us they were happy with their care and spoke positively regarding their experiences and interactions with all staff. We observed staff treating patients and/or their representatives with dignity; staff were respectful of patients' right to privacy and to make informed choices.

We found that staffing levels and morale in the hospital were good; with evidence of good multidisciplinary team working and open communication between staff. Staff feedback was positive; they told us that they were happy, well supported and that there were good working relationships throughout the hospital.

We identified good aspects in respect of the delivery of front line care within the hospital. However, we did identify a significant safety concern in relation to intravenous fluid management for one patient.

We undertook a detailed review of the current arrangements for governance and managerial oversight within the hospital. We identified a number of areas of significant concern in relation to the overarching governance structure, medical governance arrangements and management of incidents/events.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	11	10

Eleven areas for improvement were identified against the regulations, these related to:

- clinical and organisational governance;
- medical governance;
- notifiable events/incidents;
- management of complaints;
- patient fluid management;
- management of venous thromboembolism (VTE);
- laser safety;
- antimicrobial stewardship;
- admission procedures; and
- the outpatients department.

Ten areas for improvement were identified against the standards, these related to:

- oversight of clinicians;
- implementation of the International Dysphagia Diet Standardisation Initiative (IDDSI);
- policy development/guidance documents;
- estates management and the new endoscopy suite;
- laser safety;
- discharge letters; and
- patient care records.

On 24 January 2019, we provided detailed feedback to Ms Graham, Chief Executive/Matron (Responsible Individual) and some members of the management team regarding the inspection findings. During this meeting, we discussed the hospital's strengths and the areas of improvement identified during our inspection. We noted that no members of the UIC's Senior Medical Management Team (SMMT) attended this feedback meeting.

We requested a further feedback meeting with members of the SMMT. The second feedback meeting took place on 19 February 2019, at which UIC were represented by Ms Graham, the Chair of the Clinical Governance and Medical Audit Sub-Committee (CGMASC), the Chairman of the Board of Directors, a medical member of the Board of Directors, the Responsible Officer (RO) for UIC and the Chair of Medical Staff Committee. At this meeting, we highlighted the importance of the hospital's SMMT receiving and understanding key messages relating to good practices and areas for improvement identified during our inspection.

At both feedback sessions we discussed the actions which are required within the Quality Improvement Plan (QIP). The timescales for completion of these actions commence from the date of our inspection.

4.2 Enforcement action taken following our inspection

In response to concerns identified during and following our inspection, we invited Ms Diane Graham, Chief Executive/Matron (Responsible Individual) and a representative from the SMMT to attend a serious concerns meeting in RQIA on 17 July 2019. At this meeting we discussed our concerns in relation to governance; medical governance; notifiable events/incidents and complaints management.

Ms Graham and the Chair of the CGMASC attended the serious concerns meeting, where the required actions to address our concerns were agreed. These actions are described throughout this report. We advised that progress relating to the required actions will be monitored on a monthly basis. A follow-up unannounced inspection of UIC is likely to be required to ensure improvements and compliance is achieved.

5.0 How we inspect

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

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

During our inspection, our Lay Assessor, spoke with patients and distributed questionnaires to patients. We did not receive any completed patient questionnaires following the inspection. We also invited staff to complete an electronic questionnaire during the inspection. We did not receive any completed staff questionnaires following this inspection.

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

During our inspection, we met with the following staff: Ms Graham, Chief Executive/Matron, quality and education sisters, medical staff, nursing staff, healthcare assistants, allied health professionals (AHPs), catering staff, cleaning staff, administration staff and the hospital's nominated estates and facilities manager.

We inspected Ward1, Ward 2, and the theatre department including the laser equipment, the outpatients department and the new endoscopy department.

During the inspection a sample of records were examined in relation to each of these areas inspected.

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

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection

The previous inspection of the hospital was an announced care inspection undertaken on 4 June 2018, following that a QIP was completed and returned by Ms Graham, Chief Executive/Matron, this was approved by the care inspector.

6.2 Review of areas for improvement from the previous inspection on 4 June 2018

<table>
<tr><th colspan="3">Areas for improvement from the previous inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Minimum Care Standards for Independent Healthcare Establishments (2014)</th><th>Validation of compliance</th></tr>
<tr><td>Area for improvement 1

Ref: Standard 20.2

Stated: Second time</td><td>The Registered Person shall strengthen IPC arrangements as follows:

• Develop a risk assessment/screening tool for Carbapenem-Resistant Enterobacteriaeaca (CRE) and Carbapenem-producing Enterobacteriaeaca (CPE);
• Review the outbreak of an infection plan/policy to be more specific on the roles and responsibilities of staff within the hospital in the event of an outbreak;
• A clear definition for surgical site infection should be established; and
• The hospital should explore linking with the regional joint replacement surgical site infection surveillance register, thus allowing for meaningful benchmarking.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
UIC provided copies of the following documents;

• the infection control risk assessment form which included MRSA, CPE and CJD;
• the policy for the management of an outbreak of infection which had been further developed as discussed above;
• the Surgical site infection policy; and
• a copy of the invoice for subscription to the regional joint replacement surgical site.</td></tr>
</table>

6.3 Current inspection findings

6.4 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.

6.4.1 Clinical and organisational governance

We reviewed a sample of records and minutes of meetings and discussed the hospital's governance arrangements and managerial oversight with a number of staff. This included meeting with the Chairman of the Board of Directors, Ms Graham, Chief Executive/Matron, the Chair of the Medical Staff Committee (equivalent of a Medical Advisory Committee) and the Responsible Officer (RO) for the hospital.

We examined various aspects of the governance systems in place within the hospital and assessed that it was overly centralised, reliant on individuals, and had existed in its current form for a significant number of years. We recognised that the services provided by the hospital are expanding and that it is developing into a more complex organisation. We were concerned that current governing systems depend too heavily on a small number of key personnel, in particular the Chief Executive/Matron.

We did not find evidence that the UIC's senior management team (SMT) was able to describe a sufficiently effective governing system, i.e. a system that allowed SMT to effectively analyse information and intelligence, monitor quality, identify emerging risks and assure themselves that high quality care and treatment was being provided.

We were informed that five Deputy Ward Sisters have recently been appointed to the hospital and we considered this provided an opportunity for SMT to review the effectiveness of the current governance systems. We recommended that more responsibility is devolved to clinical leaders across the organisation and to the wards and clinical teams. SMT could then be assured that there is active local monitoring and oversight leading to an effective working governance system.

At our Serious Concerns meeting on 17 July 2019, Ms Graham, Chief Executive/Matron and the Chair of CGMASC advised us of their intention to dedicate one additional full time staff member to work on strengthening the governance systems across the hospital.

Due to our concerns regarding governance arrangements expressed during and following the inspection, the following actions are required by UIC:

- undertake an urgent review of governance arrangements across the hospital; the governance structure, the role and function of committees and roles and responsibilities of key senior personnel;
- the Board of Directors must demonstrate appropriate assurance that the person(s) undertaking the governance review has the appropriate skills, experience and competency to complete this work;
- share the terms of reference for the above governance review with RQIA and confirm the proposed timescale for completion of the review;

- dedicate 1 WTE staff member to work on governance across the hospital;
- link with other independent healthcare providers by way of learning and support as work on the above governance review is progressing;
- implement recommendations arising from the governance review through a detailed action plan;
- share regular (monthly) updates on the progress of the above governance review with RQIA.

6.4.2 Clinical Governance and Medical Audit Sub-Committee (CGMASC)

We examined the functions and effectiveness of the hospital's Clinical Governance and Medical Audit Sub-committee. We acknowledged that the role and function of this committee has strengthened over recent years. We found documentation to evidence that this committee reviews clinical quality indicators and other relevant information, e.g. patient transfers out to other acute hospitals. We were not assured by the information and data used by this committee to inform their work. We found evidence of some constructive challenge by this committee in relation to governance. We highlighted that this level of oversight and questioning is expected and required to ensure the ongoing provision of a safe services within the hospital.

6.4.3 Medical Governance and Medical Staff Committee

Standard 30 of The Minimum Care Standards for Independent Healthcare Establishments (July 2014), outlines the role and function of a medical advisory committee (MAC). We examined the structure and function of the Medical Staff Committee (MSC), and confirmed that this group undertakes the MAC function for the hospital. The MSC has a very important role in UIC and the role and function of this committee needs to be strengthened providing assurance and evidence of safe practice to the Board of Directors in UIC and to RQIA. The governance review recommended following this inspection should include examination of the effectiveness of this committee in view of the role and functions required in the context of the Minimum Standards.

We highlighted that the MSC has an important advisory function, as outlined within the Minimum Standards. The MSC should provide the hospital with a mechanism to secure resolved clinical advice as required, and it should also provide a forum for discussions with clinicians practising in the hospital on a continuing basis.

We reviewed UIC's arrangements for granting practising privileges to consultants, the process for application, granting, maintenance and withdrawal of practising privileges and how the hospital assures good medical governance. We had significant concerns in this regard and medical governance was discussed further at the serious concerns meeting held with UIC representatives on 17 July 2019.

We were advised that the MSC is responsible for ensuring that there is a clear summary statement outlining the requirements for granting practising privileges. Ms Graham outlined to us the process for granting practising privileges and confirmed that medical practitioners meet with her prior to their practising privileges being granted. We highlighted that systems should be in place to review practising privileges agreements every two years on a rolling/continual basis; we were not assured that a robust system was in place in this regard.

An issue in relation to practising privileges was brought to our attention following the inspection. We were advised that doctors, who appeared not to have been granted practising privileges by the MSC, were working under the supervision of consultants (who themselves had been granted practising privileges) within the hospital.

This practice was confirmed Ms Graham, Chief Executive/Matron and the Chair of CGMASC at the serious concerns meeting held on 17 July 2019. We advised that this practice should cease immediately; there is no provision within The Independent Health Care Regulations (Northern Ireland) 2005 or the Department of Health (DOH) Minimum Care Standards for Independent Healthcare Establishments (July 2014) for clinicians to work in the hospital other than working under practising privileges arrangements.

We noted that there are in excess of 400 clinicians with practicing privileges who may provide care or treatment in UIC. A small number of these clinicians (approximately 30) are doctors working in purely private practice, the remainder work in both private and HSC/NHS practice. We confirmed that the hospital is a designated body and has an identified Responsible Officer (RO) with whom doctors working in purely private practice are connected. The remaining doctors (up to 370) are not connected with UIC for the purposes of revalidation, rather they complete their annual appraisal and medical revalidation through their employing organisations which are either local HSC Trusts or other HSC/NHS organisations.

During our inspection we discussed current arrangements supporting medical appraisal and revalidation with the RO, the Chief Executive/ Matron (also the Responsible Person) and the Chair of the MSC in the hospital. We highlighted the importance of ensuring that the hospital's system to support and govern medical appraisal and revalidation are appropriately robust. We recommended that the RO should establish and maintain close links with other ROs (particularly in Northern Ireland). We recommended that the RO should ensure that private doctors working in the hospital complete whole practice appraisal with appraisers who have appropriate skills and knowledge, and in accordance with best practice guidance. He/she should ensure the hospital has robust arrangements to facilitate exchange of information with other healthcare organisations (HSC and/or Independent Sector) where there are actual and/or potential concerns regarding an individual's clinician's practice.

We reviewed the register of purely private doctors working in the hospital, which listed 30 names; we randomly selected the personnel files of six of these doctors. We found that this register was not up to date as we could not obtain two doctor's files as they no longer practised at the hospital. When we reviewed and examined the personnel files of the other four selected private doctors' files, two of the four files did not include evidence of current professional indemnity insurance or current information in respect of appraisal and revalidation. In addition, the files did not contain clear evidence that the private doctors had completed training in keeping with RQIA's mandatory training guidance. An additional four files of Consultant Orthopaedic Surgeons, who had operated on patients just prior to our inspection were also reviewed. We found these files also did not include current information in respect of the doctors' appraisals, revalidation and professional indemnity.

We concluded that the systems in place for the management of practising privileges, for the doctors working in the hospital, were not robust and records retained were not accurate or up-to-date. UIC must undertake the following actions to ensure systems are implemented for good medical governance:

- urgently review and resolve the issue of medical practitioners working in the hospital under the supervision of consultants rather than under practising privileges arrangements;
- ensure that all consultants with practising privileges have provided the required documentation, to maintain their ongoing practising privileges agreements;
- share with RQIA the operating procedure which will be enacted if the required practising privileges documentation is not received from individual consultants by the agreed deadline;

- implement and assure a robust system for oversight and management of practising privileges as they currently operate within the hospital; and
- ensure the practising privileges agreements clearly specify the individual practitioner's scope of practice within the hospital.

We found there were good processes in place to assure the registration details of all other health and social care professionals working in the hospital e.g. nurses and allied health professionals.

We were not assured by the systems in place for development, approval, dissemination and assurance of adherence to a range of policies e.g. venous thromboembolism (VTE), fluid management and anti-microbial/antibiotic stewardship. We considered that it was important that UIC's SMT recognise its responsibilities to set the expected standards of practice for all staff delivering care within the hospital. Systems are required to effect the approval and implementation of UIC's policies and to define expectations in respect of any exemptions. Where there is a clinical rationale for practice outside of these policies this should be agreed and clearly documented by the staff responsible for providing care.

6.4.4 Clinical Quality Indicators

We found that the hospital has an agreed set of clinical quality indicators (QI's) and has systems in place to monitor these. The Quality and Education Department centrally collates data, which the Clinical Governance and Medical Audit Sub-Committee (CGMASC) reviews regularly.

The Quality and Education Department provides information to the Chief Executive/Matron and responds to any queries raised by the CGMASC. However we did not find sufficiently robust arrangements for the triangulation and analysis of information or identification of issues/trends emerging throughout various parts of the hospital's governance system. For example, we did not find evidence of analysis of any trends that may relate to a particular ward/clinical area or the practice of an individual. We highlighted that the hospital's regular review of clinical quality indicators should involve a multi-disciplinary group of people who have the knowledge and skills to review information/data/trends and to assess the potential impact of changes in these indicators.

We outlined the value of collecting QI's in a paper or electronic dashboard format relating to each of the clinical areas. This would make the information visible to staff, would enable spot-checking and would prompt discussions at a clinical level. This would also enable trends or soft intelligence to be captured which would then be used and fed into the hospital's overall governing system.

We found that the Quality and Education Department currently reports directly to the Chief Executive/Matron and in that respect, we again highlighted concerns that systems are overly centralised and rely on individual staff members. To enable the hospital to demonstrate and evidence a functioning live governance system, we recommended arrangements are developed to decentralise the governing system to promote local ownership of good governance in the clinical areas/departments and to ensure there is sufficient space for learning and reflection on issues emerging.

We suggested that the newly appointed Deputy Ward Sisters could potentially act as quality leads for their respective clinical areas, which would facilitate identification of local issues and trends much earlier.

In addition, devolving responsibility for the monitoring of performance to Deputy Ward Sisters is likely to stimulate suggestions relating to improving services, as well as encouraging a better understanding and resolution of any complaints or concerns arising.

6.4.5 Notifiable Events/Incidents

We reviewed arrangements in place for the management of notifiable events/incidents and found that not all notifiable events/incidents were reported appropriately by the hospital to RQIA.

We reviewed notifications submitted to us since the previous inspection, which demonstrated that three notifiable events/incidents were reported to us in 2018. However, all three incidents were notified to RQIA following an active request by inspectors. In-depth discussions were held with Ms Graham relating to the incident notification process and we reinforced which events must be notified to RQIA in accordance with legislation. We found that the current system of reporting and investigating incidents is over centralised and overly reliant on a small number of key personnel and we encouraged the SMT to reflect on the robustness of this arrangement.

Following our inspection, three events were notified to us relating to patients transferred out from UIC to other acute hospitals following the same/similar surgical procedure. The information provided was not sufficient and inspectors sought additional information and assurances from the hospital. The response received following these requests did not provide us with the necessary assurances that the hospital had conducted effective investigations into the matters highlighted or that the internal governance system had identified potential patterns or trends. As a result, management of notifiable events/incidents was identified as an area for discussion in our serious concerns meeting held on 17 July 2019. Following the serious concerns meeting, the following actions were required by UIC:

- review the management of events/incidents to ensure that the system operates effectively and does not rely on a small number of key personnel;
- information relating to events/incidents must be provided to RQIA in a timely way. If the timescale for the provision of full information is not workable, robust interim information must be provided along with details of the initial assessment undertaken by UIC, the reason for the delay and the proposed date for provision of complete information;
- share with RQIA a copy of the report of UIC Board of Director's independent assessment of transfers out following the three identified surgical events;
- ensure that any information submitted to RQIA via email is on headed paper, signed, dated, version controlled (as applicable) and password protected; and
- implement recommendations arising from the above review of the management of events/incidents through a detailed action plan.

6.4.6 Complaints

We confirmed that the hospital has a complaints policy in place. We traced the active management of particular complaints through various parts of the hospital's governance system and found evidence of the complaints being discussed with various groups and at various committees e.g. CGMASC. We were not assured that the arrangements in place were sufficiently robust to ensure that complaints were effectively managed and responded to.

We reviewed the complaints management documents used by the hospital and considered the wording may not accurately reflect the hospital's responsibilities to patients.

We recommended that UIC should ensure that the content of the standard response letter, which is provided to any person making a complaint to the hospital, is reviewed to ensure the complainant is clear that the hospital has a key role and responsibility in relation to patient care and in relation to the investigation and management of complaints received.

We found that if investigating a complaint about an individual clinician, UIC requests a report from the clinician involved. We advised that in order to ensure there is a more robust and independent investigation into the complaint, the investigating officer should also source an objective independent view of the relevant medical notes and/or the matters subject to complaint.

Some staff within the clinical areas/wards were not familiar with the hospital's complaints policy and procedures or how to access these. Staff advised that they would refer complainants to the Chief Executive/Matron who would manage these directly. We recommended to UIC that all staff should have an understanding and an ownership of the complaints policy and procedure.

Arrangements for the management of complaints within UIC should be reviewed to ensure they do not rely on a limited number of personnel. This issue was also discussed during our serious concerns meeting held following the inspection. The following actions are required by UIC:

- review the hospital's complaints management system using the Independent Sector Complaints Adjudication Service (ISCAS) risk assessment template, to benchmark the current complaints system against the guidance issued by ISCAS;
- implement recommendations arising from the above review of the complaints management system through a detailed action plan; and
- undertake a training needs analysis and ensure that all staff are appropriately trained in the management of complaints. The schedule for training, along with agreed timescale for completion should be shared with RQIA.

6.4.7 Policy/Guidance and Best Practice

We highlighted the importance of evidencing appropriate implementation of best practice and/or regionally agreed guidance and circulars across the hospital.

During discussion with nursing and ancillary staff, we found staff were unfamiliar with the International Dysphagia Diet Standardisation Initiative (IDDSI), which was agreed for implementation in April 2019 and advised via a Health and Social Care Board circular issued in August 2018. Senior nursing staff and the Quality and Education Sister advised us that they were aware of the IDDSI and had decided that this was not relevant to patients in the hospital. However, we found no formal record of a risk assessment or decision-making process relating to this determination.

We also determined that UIC had not appropriately implemented NICE Clinical Guideline CG174, regarding fluid management, which is further discussed within Section 6.5.1 on page 15 of this report.

We did not find an effective system to consider adoption and implementation of regional/national guidance or DoH circulars. We recommended that a system should be established to consider such guidance/circulars in a timely manner and to determine the hospital's position on adoption and/or implementation along with agreed assurance mechanisms. The system should involve a group of appropriately qualified staff and should not be delegated to one person.

A formal record of the considerations undertaken and decisions taken should be retained. In particular, we recommended that the hospital's decision not to implement the IDDIS framework should be revisited.

As previously stated in Section 6.4.3 on page 10, the SMT should clearly state the hospital's expectations in relation to standards of practice and adherence to policies and procedures. These requirements should explicitly address when individuals' practicing privileges are reviewed. All staff including clinicians should be required to demonstrate adherence to these policies, with exemptions agreed in exceptional cases and supported by a clinical rationale. These actions would enable Ms Graham, as the Chief Executive/Matron, the Board of Directors and members of committees to assure themselves that staff and clinicians are implementing best practice and are adhering to the hospital's policies and procedures.

We identified a need for the hospital to develop, implement and assure its policies including an appropriate policy for Venous Thrombus Embolism (VTE) prevention. We recommended that the Medical Staff Committee (MSC) should contribute to and approve this policy and that prevention of VTE should be included in UIC's rolling audit programme, to provided assurance that the policy is appropriately implemented by all clinical staff.

Areas for improvement: Is the service well led?

We identified areas for improvement in relation to clinical and organisational governance; the role of the Medical Staff Committee; medical governance; clinical quality indicators; management of notifiable events/incidents; management of complaints; the development, implementation and assurance of best practice policies; and review and implementation of best practice guidance.

	Regulations	Standards
Areas for improvement	7	3

6.5 Is care safe?

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

6.5.1 Fluid management

We identified significant issues relating to the management of fluids for one patient receiving care on Ward 1 in UIC. We reviewed the patient's medical records, prescribing and recording records, nursing care records and had discussions with medical and nursing staff. We found that the patient's medical history and prescribed medications had not been fully considered when managing their fluid intake and output. We did not find evidence in the medical notes of a coherent risk assessment and/or fluid management plan. The intravenous fluids prescribed by the Resident Medical Officer (RMO) were not available in Northern Ireland and the fluids administered by nursing staff did not match the prescription written by the RMO. We found no evidence that staff had identified this discrepancy prior to administering the fluids and no established systems to check for such potential discrepancies. In addition, the nursing care records reviewed did not provide evidence of accurate oversight/management of the total fluid intake and output of this patient for each 24-hour period of care.

We identified immediate learning in relation to the management of fluids as RMOs, from outside Northern Ireland (NI), working within the hospital may not be aware of practices in fluid management which are unique to NI. This inspection finding and associated learning was escalated immediately to the Ward Manager and was discussed at length during feedback at the conclusion of our inspection. The following actions are required by UIC:

- the hospital's fluid management policy should be updated to include the amendment to NICE Clinical Guidance CG174 issued by the Chief Medical Officer (CMO) advising that Solution 18 is not available in Northern Ireland;
- the hospital's induction programme for the Resident Medical Officer (RMO) should be reviewed in respect of fluid management and should include clear information about the NI context for prescribing, management and oversight of fluids;
- any identified discrepancy between the prescribed intravenous fluid and the fluid administered must be discussed with the prescribing clinician and reported in accordance with the hospital's adverse incident/event policy and procedure;
- review the system for monitoring a patient who is on a fluid restriction to ensure that all staff are fully aware of and comply with clinicians instructions; accurate nursing and medical records must be in place for all patients on active fluid management;
- ensure nursing and medical notes are completed contemporaneously and calculations are recorded to provide an accurate account of the patient's fluid intake and output over each 24 hour period; and
- develop a rolling audit programme to provide assurance of appropriate fluid management for patients receiving care and treatment in the hospital.

We highlighted these very important learning points to the hospital during our inspection. We recommended that Consultant Anaesthetists should support the hospital to share the learning arising from this incident with all nursing and medical staff. We reminded the Chief Executive/ Matron and members of the SMMT that the hospital must understand the importance of ensuring staff are properly trained and understand fluid management.

6.5.2 Staffing

We reviewed the staffing arrangements in the hospital and found there is a multi-professional team including Consultant Surgeons; Consultant Physicians; Consultant Ophthalmologists; Consultant Anaesthetists; Nurses; Radiographers; and other Allied Health Professionals. A Resident Medical Officer (RMO) is available on site to provide medical cover and to meet the assessed needs of patients accommodated in the hospital.

We were advised by the Chief Executive/Matron and staff that there is always a Registered Paediatric Nurse available in the clinical area where a child is receiving care and treatment. The compliment of Paediatric Nurses available in the clinical areas consists of two Paediatric Nurses in Theatres, one in the Recovery Ward, one Paediatric Nurse between Wards 1 and 2, three who work night shift and Ms Graham who is also a Registered Paediatric Nurse. We recommended that UIC must keep paediatric cover under review to ensure that sufficient Paediatric Nurses are available to meet the needs of children undergoing care and treatment in the hospital at all times. This is particularly important as the hospital expands its services in the future.

We found that staffing levels and morale on the wards were good, with evidence of multidisciplinary working and good communication between staff. Staff told us that they were happy, felt supported and engaged, and that there were good working relationships throughout the hospital.

6.5.3 Recruitment and selection

We reviewed the arrangements for recruitment and selection of staff to ensure compliance with relevant employment legislation and best practice guidance. We found that a number of staff of various grades and professions have been recruited since the previous inspection. A random sample of three personnel files of newly recruited staff demonstrated that the information required by legislation had been sought and retained.

6.5.4 Safeguarding

We reviewed arrangements for safeguarding of children and adults in accordance with the current regional guidelines. We confirmed that policies and procedures were in place in relation to safeguarding and protection of adults and children at risk of harm. We spoke to staff who demonstrated they were aware of types and indicators of potential abuse and the actions to be taken should a safeguarding issue be identified, including who the nominated safeguarding lead in the hospital was. Review of the staff training record matrix demonstrated that all relevant staff had received training in safeguarding children and adults.

We found that a whistleblowing/raising concerns policy was available which provides guidance to help staff make a protected disclosure should they need or wish to. Staff confirmed that they knew who to contact should they have concerns or needed to discuss a whistleblowing matter.

6.5.5 Theatre/surgical services

There are four theatres in Block A and two theatres in Block B in the hospital. There are also two new endoscopy theatres in Block C that require approval by RQIA as part of this inspection, following the hospital's application to vary its registration. We reviewed arrangements for the provision of surgery in the hospital. We found the hospital undertakes a large volume of surgical cases (with theatres working six days a week) and that the theatres were operating effectively.

We identified that staff used a surgical checklist based on the World Health Organisation (WHO) checklist and that completion of the surgical checklist is routinely audited as part of the hospital's clinical governing system and compliance is monitored.

We confirmed that scheduling of patients for surgical procedures is co-ordinated by the Theatre Manager, the relevant surgeons and staff in the booking office. Staff confirmed that when scheduling theatre lists, the individual requirements of the patient; the type of procedure performed; availability of equipment; staffing levels required; associated risks; and level of sedation used are all taken into account.

Staff and patients confirmed that the relevant Consultant Anaesthetist visits each patient prior to surgery, to assess their general medical fitness; to review their medication; to explain the type of anaesthetic and to discuss options for post-operative pain relief. We evidenced these visits by the Consultant Anaesthetists through reviewing samples of patient records.

We observed the Consultant Anaesthetist visiting patients prior to their surgery and confirmed that Consultant Anaesthetists are present throughout the patient's surgery and on-site until the patient has recovered from the immediate effects of their anaesthetic. Staff and patients reported that the Consultant Surgeon also meets with each patient prior to their surgery to discuss the procedure and to obtain informed consent.

We found that there is an identified member of nursing staff, with theatre experience, in charge of the operating theatre at all times and a permanent record is maintained detailing the name of nurse in charge of each theatre session. We reviewed the register for all surgical procedures undertaken in the hospital and found that it contained all of the information required by legislation.

Staff confirmed that patients are observed during surgery and in the recovery room on a one-to-one basis. The hospital has discharge criteria in place to ensure patients are well enough to leave theatre recovery and to transfer to the ward area.

We noted that incident forms are used by staff to report incidents in theatre. We identified a disconnect between incident recognition and reporting and subsequent follow up actions and learning relating to incidents identified. The management of incidents has previously been discussed in section 6.4.5. page 13, of this report.

6.5.6 Endoscopy/estates

We reviewed the provision of surgical procedures using endoscopy. We established that within the theatre suites there was one operational endoscopy theatre. We noted that the hospital had requested a variation to its registration to enable it to register two new endoscopy suites within theatre Block C.

Two Heath Estates Engineers from the DoH supported this inspection of the currently operational and new endoscopy suites. The hospital's plan to extend the number of endoscopy suites will increase the number of theatres to eight in total; and will increase the total volume and complexity of surgical activities on site.

Updated guidance on 'Management and decontamination of flexible endoscopes Health Technical Memoranda's (HTM 01-06)' came into effect in early 2018 and we found this guidance has not been implemented by the hospital. We highlighted that all aspects of this guidance must be implemented, considering the structure, capacity and skills of the hospital's estates team prior to any determination regarding the hospital's request to vary it's registration to include additional endoscopy suites.

We found that the hospital's estates team currently includes one Estates Manager and three maintenance assistants. The Estates Manager is also acting as the Authorised Engineer and the Responsible Person for endoscopy procedures. We were concerned that the current estates team may not have adequate capacity and skills, considering the planned expansion and specialised services to be provided in the hospital. The estates team's responsibility currently extends to management of decontamination, ventilation, medical gases, and water safety, etc. A review of the team structures within the estates department is required, to ensure the operational roles and responsibilities outlined in the relevant Health Technical Memoranda's (HTM's) in relation to the premises' mechanical and electrical services (including decontamination) are fully met. We recommended that our findings in relation to estates would be fully considered within the hospital's application to vary their registration.

The new endoscopy suites are ready for use pending RQIA approval. It is intended that the existing endoscopy suite will move from theatre four to the new endoscopy suite and the increase in activity will be phased to allow staff to familiarise themselves with the new suite and systems. Theatre four will then undergo a refurbishment.

6.5.7 Laser Safety

We reviewed procedures in place for the safe use of laser equipment within UIC. Consultant Urologists, in accordance with medical treatment protocols, carry out surgical procedures using a laser. We found that systems were in place to review these medical treatment protocols on an annual basis.

We found a laser safety file was in place in the hospital and contained all of the relevant information in relation to the 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. We reviewed the service level agreement between UIC and their appointed LPA which expires on 31 March 2020 and found this to be a satisfactory arrangement.

We found up to date Local Rules developed by the LPA. The Local Rules contained relevant information pertaining to the laser equipment being used and had been signed by nursing and other staff involved in laser procedures. We noted that the authorised operators had not yet signed the Local Rules declaration, to confirm that they had read and would abide by these rules. During our previous inspection on 4 and 5 December 2017, an area of improvement was made regarding this issue, which we noted had not been addressed. The Laser Protection Supervisor (LPS) advised us that they would arrange for all current authorised operators to sign the Local Rules at the earliest opportunity.

Staff training records were not available for several of the authorised operators in relation to laser safety, core of knowledge and applications training for the specific laser system. The LPS committed to arranging appropriate training and place copies of the training certificates in the laser safety file.

We found safe and effective arrangements in place for the use of laser equipment including: controlled access to the environment; displaying of warning signs; controlled access to the environment and the laser operating key; clear identification of the authorised LPS and arrangements for deputisation; maintenance of equipment; servicing and use of protective equipment including eyewear.

The Local Rules detailed the protective eyewear available for staff; however, additional types of eyewear were also available on the day of inspection. In addition, the Local Rules referred to two pairs of Laservision eyewear of protection level L 2, however on the day of inspection we found that one of the sets of the Laservision eyewear had a higher protection level of L4. The LPS should discuss this matter with the LPA and update the local rules if required/as appropriate.

The hospital had a laser register in place which was completed each time the equipment was operated and this included:

- the name of the person treated;
- the date;
- the operator;
- the treatment given; 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 found that the total energy delivered during each treatment session had not been consistently recorded.

We recommended that all three parameters (frequency/single pulse energy/total energy) must be recorded on every occasion.

6.5.8 Medicines management

We reviewed arrangements for management of medicines within the hospital to ensure that medicines are safely, securely and effectively managed in compliance with legislative requirements, professional standards and guidelines.

We found that the hospital's antimicrobial medicines prescribing policy was out of date and there was no system in place to assure practices regarding the use and stewardship of antimicrobial medicines. The antimicrobial medicines policy should be updated in order to reflect current best practice and must include an effective assurance system. We highlighted the importance of the MSC proactively contributing to this policy and giving clear guidance on the use of prophylactic antibiotics by surgeons practising in the hospital. We were informed that work had commenced to refresh this policy.

We did not find a robust system for reporting to RQIA medication events which had adversely affected the well-being or safety of a patient, as required by legislation. This issue further supports our concerns relating to the effectiveness of the arrangements for notifying RQIA of incidents/events (as previously discussed in section 6.4.5). For example; an incident relating to one missing ampoule of a controlled drug had not been reported to RQIA and a robust investigation had not been undertaken to identify the cause for this loss.

We found systems for identifying, recording, analysing and learning from medicines related incidents/events and near misses. We were advised that the Senior Pharmacist and the Quality and Education Sister review medication incidents/events. These incidents/events are included for discussion, where necessary, at the senior clinical staff meetings. We were informed that when a controlled drug incident/event occurred, the Senior Pharmacist facilitated a session with the staff involved to reflect on the learning relating to the particular incident/event in question.

We were advised that when patients bring their own medicines into the hospital these are reviewed prior to use. Where they are not used, they are kept separate from other medicines and held in a safe place until the patient is discharged; when the medicines are returned to them or their representative. There was no robust system to verify that the patient's medicine regime was current and/or confirmed with the patient's General Practitioner at the time of admission to the ward. This is an integral part of the admission process and supports the safe administration of medicines; this information should be routinely verified and recorded. Pharmacy and nursing staff advised they provide patients with information regarding any new medicines prescribed within the hospital: both during their stay and as part of the discharge process.

We found that the Pharmacists and Pharmacy Assistants work as part of a multi-disciplinary team and are responsible for the provision of safe, efficient, economical and timely pharmaceutical services throughout the hospital. The Pharmacy Assistants work under the direction and supervision of the Pharmacists. Since April 2018, in addition to the Monday to Friday service, the hospital's pharmacy opens on Saturday mornings; both pharmacy and nursing staff spoke positively of this development.

Systems were in place to manage and oversee ordering and stock control, to ensure adequate supplies were available and to prevent wastage; designated staff ordered medicines. We confirmed that separate requisition/receipt records were in use for general medicines and controlled drugs.

We observed that medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. Systems were in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. There was evidence that medicine refrigerators and the contents of emergency trolleys were checked at regular intervals.

There was evidence that stock checks of controlled drugs were completed twice daily. Some controlled drugs, that are not subject to safe custody requirements, were stored in the controlled drug cupboards and stock balances were reconciled at the end of each shift, as an increased security measure.

We reviewed a sample of medicine records and found accurate recording of medicines and in cases where medicines had been delayed or doses omitted, the reason for the delay or omission had been clearly documented.

We found evidence of audits relating to the management of medicines including:

- daily temperature range monitoring of each medicine refrigerator (reviewed by the pharmacy staff at the end of each month)
- incidence of medicine errors and near miss events;
- monthly expiry date checks of the medicine stocks;
- review of patients' medicine records on the wards, completed on a daily basis from Monday to Friday; and
- review (by the pharmacist) of the dispensing of patient take home medicine packs.

6.5.9 Management of medical emergencies and resuscitation

We reviewed arrangements for management of medical emergencies and resuscitation of patients and visitors to the hospital. A wide range of policies and procedures were in place in this regard, which reflected best practice guidance. These included policies addressing:

- patient requiring portable ventilation from UIC to intensive care unit using Northern Ireland critical care transfer service (NICCATS);
- management of a deteriorating patient;
- management of chest pain, (acute ST elevation) ;
- advance directives; and
- transferring a patient to intensive care unit (ICU).

We confirmed that the emergency medicines held were in line with the British National Formulary (BNF); and that emergency equipment was available as recommended by the Resuscitation Council (UK). A system was in place to check emergency medicines and to ensure that equipment did not exceed its expiry date. An individual with responsibility for checking emergency medicines and equipment was identified. We examined the emergency trollies located in Ward 2 and the theatre/recovery area, which contained all the necessary medication and equipment. We confirmed checks are completed by the hospital Pharmacist who seals and tags the emergency medicine boxes.

Staff confirmed completion of adult and paediatric basic life support training and relevant updates. Some staff reported that they had also undertaken intermediate life support training and updates. This was also supported by the training records reviewed. Staff informed us of additional scenario based medical emergency training, provided by Consultant Anaesthetists, which they considered valuable. We were informed that there is at least one staff member with advanced life support training on duty at all times and that the Resident Medical Officer (RMO) has undertaken advanced life support training for adults and children.

In discussion with staff we were advised that patients who have a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order in place would not normally meet the admission criteria for elective surgery in the hospital. However, we were advised that if a patient with a DNACPR order attended hospital for a procedure, following discussion, appropriate arrangements would be put in place to document and review the DNACPR order.

We found that staff had a good understanding of the actions to take in the event of a medical emergency and were familiar with the location of medical emergency medicines and equipment.

6.5.10 Infection prevention control and decontamination procedures

We reviewed arrangements for infection prevention and control (IPC) and decontamination procedures in place throughout the hospital, to ensure the risk of infection for patients, visitors and staff are minimised.

There were clear lines of accountability in relation to infection prevention and control. The hospital had a designated IPC lead nurse. We spoke with the IPC lead nurse who demonstrated a good understanding of her role and responsibilities. She confirmed that she was a member of the Infection Prevention Society (IPS) and she attends meetings three times a year. Staff who spoke with us had good knowledge and understanding of IPC measures and decontamination arrangements. We confirmed that all staff had undertaken IPC training commensurate with their role.

We found that the ward and theatre environments were clean, tidy and well maintained. Infection prevention and control information was displayed on notice boards in the clinical areas and we observed good practice in relation to hand hygiene and the use of personal protective equipment. There was a range of information available for patients and staff regarding hand-washing techniques.

Patients confirmed to us that staff were diligent in carrying out hand washing when delivering care. Patients also confirmed they were screened for infections such as Methicillin-resistant Staphylococcus aureus (MRSA) prior to admission to the hospital for surgery.

We reviewed a sample of IPC audits, which included information relating to the environment; hand hygiene; and surgical site infection. We noted that the results of these audits displayed on a dedicated IPC noticeboard located in a corridor in the in-patient areas of the hospital. The compliance rate was high in relation to the outcome of the various IPC audits and action plans were formulated to address issues identified within the audits.

We found some equipment designated for patient use was stored on open shelving in the sluice area. Ms Graham confirmed that this issue would be immediately addressed. Arrangements were in place to ensure the decontamination of equipment and reusable medical devices in line

with manufacturer's instructions and current best practice. Staff confirmed that where possible single use equipment is used.

6.5.11 Outpatients Department

The Outpatient Department is a continually expanding area of the hospital with an increasing number of patients attending for appointment/review. We found that the hospital does not always hold a comprehensive medical record for each patient attending the Outpatients Department. Without this information the hospital is unlikely to have sufficiently thorough governance and oversight of the care and treatment delivered through its Outpatients Department.

We found the Outpatient Department is reliant on individual consultants providing information on their lists of patients. This is an area of significant risk for the hospital which will need to be addressed and this potentially exposes the hospital to unsafe practice and other safety risks; with no systems in place to identify and manage such risks. There was inadequate information available to inform the Outpatient Department Manager of the nature of consultations planned and provided in the department or to enable staff to prepare and provide appropriate assistance for individualised care as and when required.

We advised Ms Graham, Chief Executive/ Matron, the Chair of the Clinical Governance and Medical Audit Sub-Committee (CGMASC), the Chairman of the Board of Directors, a medical member of the Board of Directors, the Responsible Officer (RO) for UIC and the Chair of Medical Staff Committee that The Independent Health Care Regulations (Northern Ireland) 2005 clearly specifies that records should be retained in respect of patients attending for care and treatment; this includes patients attending for review in the Outpatients Department of the hospital.

UIC must undertake the following actions to ensure compliance with the regulations:

- retain a register of all patients attending the Outpatient Department;
- develop and implement a patient record management system for patients attending the Outpatients Department, which includes a contemporaneous note of each patients' medical history, all treatment provided, and all notes prepared by other health care professionals involved in their care.

We recommended that the Board of Trustees and SMT would seek assurances that healthcare professionals working in the Outpatients Department are adhering to the appropriate hospital's policies and procedures.

Through observation and discussion we noted systems were in place in the Outpatients Department to provide support by trained nursing staff should a patient receive bad news.

Areas of good practice: Is care safe?

We found examples of good practice in relation to staffing; multidisciplinary working and communication between staff; recruitment and selection; safeguarding; management of theatres/surgical services, management of medical emergencies and resuscitation; IPC and decontamination procedures; and the environment.

Areas for improvement: Is care safe?

We identified areas for improvement in relation to fluid management; provision of endoscopy services; estates management; laser safety; development of an antimicrobial medicines policy and system to audit adherence to the policy; and governance and oversight of the Outpatients Department.

	Regulations	Standards
Areas for improvement	2	5

6.6 Is care effective?

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

6.6.1 Care pathway

We visited the two inpatient wards in the hospital to understand the effectiveness of care from the time of referral to the hospital through to discharge. Ward 1 is a 14 bedded day procedure unit and Ward 2 is 32 bedded inpatient and overnight ward. Staff confirmed that patients may also be accommodated overnight in Ward 1, depending on the needs of the patients and occupancy levels in Ward 2.

Many areas of good practice were identified with respect to the care delivered. We spoke to patients who were complimentary of the quality of care and services received. We observed staff on both wards engaging positively with patients. However, we also identified some areas within each ward which need to be addressed in order to enhance the effectiveness of care.

<u>Ward 1</u>

We were concerned about the limited information available in respect of patients admitted for the first time to the ward. A suite of information is available in the patient's care records at ward level if the patient has undergone a pre-admission assessment in the hospital's Outpatient Department. However, if the patient has not undergone a pre-admission assessment there is no previous medical history or medication list available in the patient's care records at the time of admission to the ward. This was particularly notable in relation to patients admitted for day surgery procedures.

We found that the hospital's Patient Guide advises patients to bring a full list of their medication and confirmed that Consultants have medications and patient histories recorded in their medical notes, however, we noted that the medical notes are not always available for the staff on the ward. We recommended that the hospital needs to consider a system to ensure this information is available in all patient care records at the time of admission to ensure that staff at ward level are not left vulnerable in this regard. This is important as the proportion of people who require multiple medications and have complex co-morbid medical issues who attend the hospital for care and treatment is increasing.

In some instances we noted inconsistencies between patient's care records and information recorded on the planned theatre list; the procedure actually undertaken; the patient's operation notes; and the patient's discharge letter. For example, a patient who was booked for a planned surgical procedure had an additional procedure undertaken during surgery. However, the surgical notes mentioned the original planned procedure only and did not include information relating to the additional procedure and the discharge letter replicated information on the planned procedure only.

We identified that discharge letters written in triplicate books resulted in the third copy not always being legible. Discharge letters provided to all parties must be legible, accurately capture all relevant information and include the full details of all procedures undertaken. This aspect of communication is important for patient safety and continuity of care.

Ward 2

We confirmed that patients admitted for surgical procedures who require an overnight stay were generally accommodated in Ward 2. On this ward, we found that patients' nursing records were stored securely and were generally well completed. However similar to our findings on Ward 1, we found that if a patient did not have a pre-admission assessment completed in the hospital and did not bring their medication list, information about their usual medications and medical history was not routinely available to ward staff at the time of the patient's admission.

Ms Graham advised us that UIC had itself recognised this issue and advised of the hospital's view that access to the Northern Ireland Electronic Care Record (NIECR) used by the HSC would ensure access to appropriate information relating to patients presenting for admission. As there is no clear agreement or timescale for gaining access to NIECR we recommended that the hospital consider alternatives to ensure that all necessary information is available for patients at the time of their admission.

We reviewed nursing records for four patients and identified that the nursing assessments and care plans were found to be generally well recorded. However, the daily evaluation record for some patients lacked detail and it was not clear whether nursing interventions and care plans had been discussed with the patient, thereby gaining their consent. We recommended that nursing staff ensure that care plans demonstrate active involvement of the patient, wherever practicable; provide clear evidence of the care planned; the decisions made; the care delivered; and the information shared, in line with best practice and professional guidance.

6.6.2 Nutrition and hydration

We reviewed arrangements to ensure that patients had access to appropriate food and water and their nutritional needs were met. We found that nursing staff are responsible for the co-ordination of mealtimes and recording of food and fluid intake. This was previously discussed in Section 6.5.1 on page 15. We spoke with patients who gave positive feedback in relation to the availability of food and fluids, menu choices and the quality of food in the hospital.

Nursing and catering staff demonstrated a good knowledge of special diets and processes in place to ensure patients are provided with food and fluids suited to their specific dietary needs. Staff described how information relating to patients diets is shared, including specialised diets and food allergies. We concluded that the meal service was well managed, with patients receiving their meals in a timely way and assistance was provided as needed.

As discussed in Section 6.4.7 on page 14, we found that staff were unfamiliar with the International Dysphagia Diet Standardisation Initiative (IDDSI), which was agreed for implementation in April 2019. Senior nursing staff and the Quality and Education Sister advised us that they were aware of the IDDSI and had decided that this was not relevant to patients in the hospital. However, we found no formal record of a risk assessment or decision-making process relating to this determination.

6.6.3 Pain management

We reviewed the management of patients' pain and found that staff responded appropriately to the needs of individual patients through various methods including assessment, therapeutic interventions and administration of pain relief medication. We spoke with patients about their pain and they confirmed that staff responded in a compassionate and timely manner when they experienced pain.

6.6.4 Communication

We reviewed the systems and processed supporting effective communication within the hospital and found examples of good multidisciplinary working and effective lines of communication. We also found challenges in relation to overly centralised systems, or communication implementation of new policies/guidance and fluid management.

We found supportive structures in place for teams with regular staff meetings taking place. Staff confirmed that minutes of staff meetings were promptly shared following meetings and all staff had access to these.

When we spoke with staff they clearly described their roles and responsibilities and confirmed that staffing levels and morale were good in the hospital. Staff indicated that they knew who to contact when they had a concern and advised they felt they were able to raise their concerns openly and honestly. Staff confirmed that management were responsive to suggestions or concerns raised. However, we found no evidence that the discrepancy in relation to fluid management for a patient, previously discussed in Section 6.5.1 on page 15, had been raised with the RMO or Consultant Surgeon.

Through observation and discussion, we confirmed that nursing and care staff attend a handover meeting/safety brief at the beginning of each shift and that a written record is retained to evidence the content and format of the handovers. We recognised this as an example of good practice.

Patients indicated that their interactions with all grades of staff were positive and they received the necessary information in relation to their care and treatment.

6.6.5 Discharge planning

We reviewed discharge planning arrangements and found that there was full engagement with patients and/or their representatives. Multi-disciplinary involvement in discharge planning was evident during our discussions with staff. We found good systems for ensuring that agreed discharge arrangements are recorded and co-ordinated and that all required services are involved in the patient's ongoing care and treatment.

We were told that a discharge summary and plan is completed prior to the patient leaving the hospital. A letter is provided to the patient's General Practitioner (GP), which outlines the care and treatment provided. As previously discussed in section 6.6.1, page 24, all information provided to the GP must be legible and must accurately reflect all treatments or procedures provided.

Areas of good practice: Is care effective?

We found examples of good practice in relation to the delivery of care; pain management; meals and mealtimes; communication between patients and staff; and multidisciplinary discharge planning.

Areas for improvement: Is care effective?

We identified areas for improvement in relation admission procedures; discharge letters; and patient care records.

	Regulations	Standards
Areas for improvement	2	2

6.7 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.

6.7.1 Person centred care

We spoke with patients, looked at care records, observed care practice and met with various grades of staff to understand how the hospital ensures that patients receive person centred care; we found good systems in place across the hospital.

Patients told us they were very happy with their care and we observed positive interactions between staff and patients throughout our inspection. Staff treated patients with compassion, dignity and respect, introducing themselves and explaining procedures to patients in a kind and caring manner. A call bell system was in place for patients to attract the attention of staff, patients confirmed it was easy to use and that staff responded and attended to their needs in a timely way.

Staff wore badges with their name and profession/designation clearly visible and legible. Patients reported that staff spoke with them at the beginning of each shift and that they knew who to contact should they require any assistance or information.

6.7.2 Breaking bad news

Staff reported that when that bad news is delivered to patients and/or their representatives this is done by experienced professionals and in accordance with the hospital's policy and procedure.

We were advised that when bad news is shared, future treatment options were discussed and fully documented in the patient's care records. With the patient's consent information is shared with their GP, their representatives and/or other healthcare professionals involved in their ongoing treatment and care.

6.7.3 Patient Engagement

We examined the methods used by the hospital to obtain the views of patients and/or their representatives through speaking with patients, staff and reviewing relevant documentation. We found this to be an integral part of the service delivered in the hospital. In-patients, day patients, parents and children are offered an opportunity to provide feedback on their care through completion of a questionnaire. A child friendly questionnaire is also available which uses pictures.

We found that information received from these questionnaires was available to patients and other interested parties within an annual report. This report was displayed within the hospital and made available through the hospital's website. We reviewed meeting notes and found that the SMT use the annual report to inform service delivery and improvement to improve services.

On the first day of our inspection our Lay Assessor spoke with patients and family members across the hospital and reported that the feedback from patients was positive. Those spoken with felt that they were kept well informed and expressed a high level of satisfaction with the care and treatment provided in the hospital.

Areas of good practice: Is care compassionate?

We noted examples of good practice in relation to ensuring the core values of privacy and dignity were upheld; providing the relevant information to allow patients to make informed choices; and considering the patient feedback to improve services.

Areas for improvement: Is care compassionate?

We did not identify areas for improvement during the inspection in relation to compassionate care.

	Regulations	Standards
Areas for improvement	0	0

6.8 Patient and staff views

During our inspection, our Lay Assessor spoke with patients and distributed questionnaires to patients for completion and return to RQIA. We did not receive any completed patient questionnaires following the inspection. Other members of the inspection team also spoke with patients. We found that patients were very satisfied with the care and treatment provided in the hospital.

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

6.9 Quality improvement plan (QIP)

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Graham, Chief Executive/Matron (Responsible Individual), the Chair of Clinical Governance and Medical Audit Sub-Committee, the Chairman of the Board of Directors, a medical member of the Board of Directors, the Responsible Officer and the Chair of the Medical Staff Committee on two occasions during feedback delivered on 24 January 2019 and 19 February 2019. They were also discussed during our serious concerns meeting held on 17 July 2019. The timescales for the implementation of these improvements commence from the date of this 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. It is the responsibility of the Registered Provider to ensure that it 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.

7.0 Areas for improvement

Areas for improvement have been identified in which 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 (DOH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

7.1 Actions to be taken by the service

The QIP should be completed and should 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 and The Minimum Care Standards for Independent Healthcare Establishments (2014)

Clinical and Organisational Governance

Area for improvement 1

Ref: Regulation 17

Stated: First time

To be completed by:
9 February 2020

The Registered Person shall ensure the following actions are addressed in relation to clinical and organisational governance:

- undertake an urgent review of governance arrangements across the hospital; the governance structure, the role and function of committees and roles and responsibilities of key senior personnel;
- the Board of Directors must demonstrate appropriate assurance that the person(s) undertaking the governance review has the appropriate skills, experience and competency to complete this work;
- share the terms of reference for the above governance review with RQIA and confirm the proposed timescale for completion of the review;
- dedicate 1 WTE staff member to work on governance across the hospital;
- link with other independent healthcare providers by way of learning and support as work on the above governance review is progressing;
- implement recommendations arising from the governance review through a detailed action plan;
- share regular (monthly) updates on the progress of the above governance review with RQIA.

Ref: 6.4.1

Response by Registered Person detailing the actions taken:

- A review of governance arrangements within the Ulster Independent Clinic was commissioned by the Board of Directors.
- Prior to commencement terms of reference for the review were compiled and shared with RQIA.
- The CV of the person undertaking the governance review along with references were obtained, and approved by the Board of Directors.
- The review commenced on Tuesday 17th September 2019 for a six week period, and an Integrated Governance Review and Action Plan complete, and communicated to the Chairman of the Board of Directors on 31/10/2019.
- One WTE member of staff has been appointed to work on governance across the hospital, and will take up post once their position has been filled.
- A link has been established with Justine Hillier at Nuffield Guildford
- Monthly updates on progress relating the governance review have been submitted to RQIA.

Medical Governance and Medical Staff Committee	
Area for improvement 2 **Ref:** Regulation 19 **Stated:** First time **To be completed by:** 3 September 2019	The Registered Person shall ensure the following actions are addressed in relation to the medical governance: • urgently review and resolve the issue of medical practitioners working in the hospital, under the supervision of consultants, rather than under practising privileges arrangements; • ensure that all consultants with practising privileges have provided the required documentation, to maintain their ongoing practising privileges agreements; • share with RQIA the operating procedure which will be enacted if the required practising privileges documentation is not received, from individual consultants, by the agreed deadline; • implement and assure a robust system for oversight and management of practising privileges they currently operate within the hospital; and • ensure the practising privileges agreements clearly specify the individual practitioner's scope of practice within the hospital. **Ref: 6.4.3**
	Response by Registered Person detailing the actions taken: • Processes have been reviewed and the requirement for practising privileges arrangements to apply to surgical assistants actioned. Communication issued to all consultants regarding this and information currently being received from all surgical assistants. • All medical staff (including doctors working in a purely private capacity), have been contacted regarding renewal of practising privileges, e-mail communication has been issued to all consultants regarding this. A spreadsheet has been populated detailing all documentation received, including scope of practice, and regular updates provided to the Medical Advisory Committee. A schedule has been drawn up detailing action required if documentation is not received from individual consultants.
Area for improvement 3 **Ref:** Regulation 19 **Stated:** First time **To be completed by:** 9 November 2019	The Registered Person shall address the following matters with respect of private doctors working in the hospital: • the Responsible Officer (RO) should ensure he/she is assured that doctors working in a purely private capacity are completing annual appraisal with a suitable trained and skilled medical appraiser; • the register of private doctors should be current and kept up to date; and • all doctors working in a purely private capacity should ensure that they complete mandatory training in in keeping with the RQIA's training guidance, training records should be retained the hospital should retain up to date records of completion for this training. **Ref: 6.4.3**

	Response by Registered Person detailing the actions taken: • The Responsible Officer (RO) reviews and maintains the list of consultants which he has responsibility for, and there are a cohort of consultants available to undertake appraisals. • Evidence of completion of annual appraisal is required under the 'Conditions of Membership', and evidence collected, and recorded on the database of consultants with practising privileges as detailed in 'Area for Improvement 2'. • Private doctors training records are included as part of their appraisal process.
Area for improvement 4 **Ref:** Standard 10.5 **Stated:** First time **To be completed by:** 24 March 2019	The Registered Person shall address the following matters with respect to the oversight of all clinicians working in the hospital: • the Responsible Officer (RO) should ensure closer links are established with ROs in the wider Health and Social Care (HSC) and that senior network; and • develop a robust system for exchanging information with other relevant HSC or Independent Sector organisations when there are concerns or potential concerns regarding an individual clinician's practice. **Ref: 6.4.3**
	Response by Registered Person detailing the actions taken: • The Responsible Officer for the Ulster Independent Clinic is a member of the Northern Ireland RO Forum. • As part of the induction process, each consultant granted practising privileges is required to bring a letter of introduction from their clinical director. If there are concerns regarding an individual clinicians practice, the clinical director/medical director in the Trust or independent sector organisation where he /she works are contacted. • Representatives from the Clinic including the RO meet regularly with the GMC Liaison Officer, who may also be contacted at any time should an issue arise with regard to a clinicians practice.
Notifiable Events/Incidents	
Area for improvement 5 **Ref:** Regulation 28 (1) (2) **Stated:** First time **To be completed by:** 9 January 2020	The Registered Person shall ensure the following actions are addressed in relation to the management of notifiable events/incidents: • review the management of events/incidents to ensure that the system operates effectively and does not rely on a small number of key personnel; • information relating to events/incidents must be provided to RQIA in a timely way. If the timescale for the provision of full information is not workable, robust interim information must be provided along with details of the initial assessment undertaken by UIC, the reason for the delay and the proposed date for provision of complete information; • ensure that any information submitted to RQIA via email is on headed paper, signed, dated, version controlled (as applicable)

	and password protected; and • implement recommendations arising from the above review of the management of events/incidents through a detailed action plan. **Ref 6.4.5**
	Response by Registered Person detailing the actions taken: A review of the management of events / incidents has formed part of the Governance Review, and included in the action plan. A pro forma has been created which is available in all departments, to act as an aide memoire to staff of RQIA Notifiable Events. If an event occurs which requires reporting to RQIA, the form is completed and forwarded to Nursing Administration within 24 hours of the event. This form is then forwarded to the person in charge of the Clinic (Monday to Friday) who reports the incident onward to RQIA. The RQIA Notifiable Events form is designed to include information which needs to be submitted via the RQIA web portal. Follow-up information may be provided to RQIA at a later date. This change in practice has been communicated to staff via the meeting structure within the hospital, and policies have been amended to reflect the change. Changes which are introduced as a result of adverse events may include changes in clinical practice, policy / procedure changes, or equipment changes. The audit of accidents / incidents is discussed monthly, and information disseminated via the hospital meeting structure. Information submitted to RQIA via e-mail is on headed paper, signed, dated, version controlled (as applicable), and password protected.
Management of Complaints	
Area for improvement 6 **Ref**: Regulation 23 **Stated:** First time **To be completed by:** 9 January 2020	The Registered Person shall ensure the following actions are addressed in relation to the management of complaints: • review the hospital's complaints management system using the Independent Sector Complaints Adjudication Service (ISCAS) risk assessment template, to benchmark the current complaints system against the guidance issued by ISCAS; • implement recommendations arising from the above review of the complaints management system through a detailed action plan; and • undertake a training needs analysis and ensure that all staff are appropriately trained in the management of complaints. The schedule for training, along with agreed timescale for completion should be shared with RQIA • . **Ref: 6.4.6**

	Response by Registered Person detailing the actions taken: • A review of the hospital complaints management system using the ISCAS risk assessment template has been completed for the 2017, 2018 and 2019 complaints, and action required has been included in the Governance Review Action Plan. • Heads of Department in the first instance are to complete the ISCAS on-line complaints management training programme, this will be extended to all staff. It anticipated training for Heads of Department will be completed within 3 months. •
Fluid Management	
Area for improvement 7 **Ref:** Regulation 15 (1) **Stated:** First time time **To be completed by:** 24 February 2019	The Registered Person shall address the following matters with respect to fluid management : • The hospital's fluid management policy should be updated to include the amendment to NICE Clinical Guidance CG174 made by the Chief Medical Officer advising that Solution 18 is not available in Northern Ireland; • the hospital's induction programme for the Resident Medical Officer (RMO) should be reviewed in respect of management and include clear information about the Northern Ireland context for prescribing, management and oversight of fluids; • any identified discrepancy between the prescribed intravenous fluid and the fluid administered must be discussed with the prescribing clinician and reported in accordance with the hospital's adverse incident/event policy and procedure; • review the system for monitoring a patient who is on fluid restriction to ensure that all staff are fully aware of and comply with the clinicians instructions, accurate nursing and medical records must be in place for all patients on active fluid management; • ensure nursing and medical notes are completed contemporaneously and calculations are recorded to provide an accurate account of the patient's fluid intake and output; and • develop a rolling audit programme to provide assurance of appropriate fluid management for all patients receiving care and treatment in the hospital. **Ref: 6.5.1**
	Response by Registered Person detailing the actions taken: • The 'Ulster Independent Clinic policy on adult fluid management' has been updated to reflect the circular issued by the NI Chief Medical Officer HSC (SQSD) (NICE CG 174) 17/14, that No. 18 solution is not available in Northern Ireland. • The induction programme for Resident Medical Officers (RMO) has been expanded to include a section on induction to Pharmacy – this includes information that No. 18 solution is not available in Northern Ireland. The programme also directs the RMO to the relevant policies on adult and paediatric fluid management which are available on the hospital intranet.

	• Any patient with a fluid restriction has this documented on their fluid balance chart, in their medical notes and nursing care plan, and the details of the restriction are passed on during handover reports. Additional information regarding this has been added to 'Ulster Independent Clinic policy on fluid management', which is available on the hospital intranet. • Issues regarding completion of fluid balance charts have been included in ongoing staff training for nurses and RMOs, on adult fluid management training. • An audit of fluid balance charts was completed in February 2019 and a report on the audit findings compiled. Feedback on the audit was presented to the Senior Clinical Staff meeting, and a summary sheet distributed to all clinical areas. The results of the audit have been incorporated into the adult fluid management training. A re-audit is planned following completion of training.
Outpatients Department	
Area for improvement 8 **Ref**: Regulation 21 **Stated:** First time **To be completed by:** 9 November 2019	The Registered Person shall ensure that the following matters are addressed in relation to the Outpatients Department: • retain a register of all patients attending the Outpatient Department; and • develop and implement a patient record management system, which includes a contemporaneous note of each patients' medical history, all treatment provided, and all notes prepared by other health care professionals involved in their care. **Ref: 6.5.11**
	Response by Registered Person detailing the actions taken: • A register of all patients attending for Outpatient consultations is maintained on the Clinic's patient management system. • All Consultants using the medical secretarial service at the Clinic have a G.P. summary letter of each patient's consultation typed in-house and these are retained on the Clinic's database. • Consideration is being given to introduce a system for ensuring a copy of each patient's referral letter is retained electronically. Access to the NI Electronic Care Record system would greatly facilitate this process and enable timely sharing of patient information.
Policy/Guidance and Best Practice	
Area for improvement 9 **Ref:** Regulation 15 (1) (b) **Stated:** First time **To be completed by:** 24 April 2019	The Registered Persons shall address the following matters with respect to the management of venous thromboembolism (VTE): • review the current VTE management policy and ensure that it is in keeping with NICE guideline [NG89]; • ensure that the MAC contributes to and approves the hospital's updated VTE policy; • ensure that VTE risk assessments are undertaken and

	documented in respect of all patients admitted for surgical procedures; and • include VTE in the hospital's rolling programme of audit, to provide assurance of best practice in implementation of VTE risk assessments and related actions. **Ref: 6.4.7**
	Response by Registered Person detailing the actions taken: • The VTE policy has been reviewed to reflect NICE guideline (NG89), and is with the Medical Advisory Committee for ratification. • Medical and nursing VTE risk assessments are undertaken and documented for all patients admitted. • Completion of VTE risk assessment forms is included in the quarterly health record audit.
International Dysphagia Diet Standardisation Initiative (IDDSI)	
Area for improvement 10 **Ref**: Standard 9.1 **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall address the following issues in relation to IDDSI and the implementation of new guidance: • review previous decision making in relation to the implementation of IDDSI; • ensure that all relevant staff are aware of IDDSI and the implications for patients attending or being admitted to the hospital who may have swallowing difficulties or require modified diets; and • ensure all staff receive training in relation to the application of the IDDSI guidance which is relevant to their roles and responsibilities. **Ref: 6.4.7**
	Response by Registered Person detailing the actions taken: • The hospital policy relating to patient meals has been revised, along with documentation for ordering patient meals to include IDDSI. The policy and posters are available in the ward areas, and the catering department. • Training is being undertaken for staff on applying the IDDSI guidelines, according to their roles.
Policy Development/Guidance Documents	
Area for improvement 11 **Ref**: Standard 19 **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall address the following issues in relation to policy development and the implementation of best practice guidance : • develop a system to review guidance documents, circulars and notices in a timely manner; • ensure the review process involves a group of appropriately qualified staff and is not delegated to one person; and

	• retain a record of the decisions made and outcomes agreed or recommended following the review of each guidance document. This note should clearly outline the decision making process(es). **Ref: 6.4.7**
	Response by Registered Person detailing the actions taken: • Patient safety communications are received from various sources e.g. RQIA and DHSSPS by Matron/Chief Executive, the Senior Pharmacist and the Quality and Education Sister. The communications are considered, disseminated and actioned as required. Patient safety communications are considered at the Senior Clinical Staff, Health and Safety Committee, Risk Management Committee, Medical Advisory Committee, and Clinical Governance and Medical Audit Sub-committee meetings. The Quality and Education Department updates the NI Safety Alert System on-line, and maintains records. • Consideration is being given to the formation of a Practice Development Group, the membership of which would include Junior Sisters from clinical areas, along with staff from the Quality and Education Department. Part of the remit of this group would be to review published safety and guidance documents, and support changes in practice and audit as appropriate.
Endoscopy/Estates	
Area for improvement 12 **Ref**: Standard 21.2 **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall implement in full the key findings advised by DoH Health Estates following their audit of the hospital's decontamination equipment, facilities and processes. **Ref: 6.5.6**
	Response by Registered Person detailing the actions taken: • The key audit findings as issued by DoH Health Estates have been addressed. • A major refurbishment of the Endoscopy Decontamination area is scheduled to commence in January 2020.
Area for improvement 13 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall review the team structures within the estates department to ensure the operational roles and responsibilities outlined in the relevant Health Technical Memoranda (HTM's) in relation to the premises' mechanical and electrical services (including decontamination) are fully met. **Ref: 6.5.6**

	Response by Registered Person detailing the actions taken: • A review of the operational roles and responsibilities in the Estates Department was undertaken in January 2019. This will continue to be kept under review. • The services of an AED have been secured to advise with regard to current HTM requirements.
Laser safety	
Area for improvement 14 **Ref:** Regulation 18 (2) (a) **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall ensure that records are retained to evidence that all clinical authorised operators using the laser have completed training in keeping with RQIA training guidance for cosmetic laser services. **Ref: 6.5.7**
	Response by Registered Person detailing the actions taken: All clinical authorised operators using the laser have completed the on-line 'Core of Knowledge' training.
Area for improvement 15 **Ref:** Standards 48.6 **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall implement a system to ensure that an authorised operator does not operate the hospital's laser equipment until they have signed a declaration to confirm that they have read and will abide by the Local Rules. **Ref: 6.5.7**
	Response by Registered Person detailing the actions taken: A signed record is maintained in the Laser Manual of authorised users to confirm they have read and will abide by the Local Rules which were updated in March 2019.
Area for improvement 16 **Ref:** Standards 48.17 **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall ensure that the Laser Protection Supervisor (LPS) informs the Laser Protection Advisor (LPA) that one set of protective eyewear available has a higher level of protection than that stated in the Local Rules. The outcome of the discussion with the LPA should be actioned and documented in the Local Rules. The Local Rules must accurately reflect the eyewear required for the laser equipment and these must be available for use. **Ref: 6.5.7**
	Response by Registered Person detailing the actions taken: The Local Rules were updated by the LPA in March 2019 to include information regarding protective eyewear and its use. Suitable protective eyewear is available in the area where lasers are used.

Area for improvement 17 **Ref:** Standards 48.10 **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall ensure that the Laser Protection Supervisor (LPS) confirms the precise exposure (to include all three parameters frequency/single pulse energy/total energy) is recorded in the laser register on each occasion the hospital's laser equipment is operated. **Ref: 6.5.7**
	Response by Registered Person detailing the actions taken: A record is maintained in the laser register of exposure for each episode of use.
Medicines Management	
Area for improvement 18 **Ref:** Regulation 15 (7) **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall ensure that the following matters are address in relation antimicrobial/antibiotic stewardship: • ensure that an anti-microbial/antibiotic stewardship policy is developed in keeping with NICE guideline [NG15]; • ensure the Medical Staff Committee and relevant clinicians/ clinical groups actively contribute to the development of the policy; • ensure the policy clearly describes the prophylactic medications that may be prescribed by clinicians practising in the hospital; and • ensure that a rolling audit programme is developed to provide assurance that the policy is being adhered to. **Ref: 6.5.8**
	Response by Registered Person detailing the actions taken: • The hospital antimicrobial policy has been rewritten by the Senior Pharmacist and Infection Control Sister, and has been ratified by the Medical Advisory Committee. • Daily checks of patient drug prescription charts are undertaken by Pharmacy staff, and formalised audits are commencing following introduction of the updated policy.
Care Pathway	
Area for improvement 19 **Ref**: Regulation 21 (1) **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall ensure that the pre-admission and admission procedures are reviewed to ensure the following information is available on admission: • the patient's up to date medical history; • confirmation that the patient's medicine regime is current and has been confirmed with the Patient's General Practitioner at the time of admission to the ward; • confirmation that an assessment tool is used by the consulting surgeon to determine the suitability of each patient for surgery and a copy is provided to ward staff as part of the admission process; and •

	• a system should be in place to review and audit the admission procedures to ensure that they are effective and robust. **Ref: 6.6.1**
	Response by Registered Person detailing the actions taken: • Currently this information is contained in the GP referral letter which the patient gives to his / her Consultant at consultation. Each admitting Consultant is required to share this information with the staff involved with the patient's admission. • Consideration will be given to a process to retain a copy of this GP referral letter so that the information will be available at the time of admission. • Currently the Clinical Quality Indicator of 'Operations postponed' audits the effectiveness of admission procedures. • The quarterly health record audit captures information with regard to patient admission documentation
Area for improvement 20 **Ref**: Standard 6.9 **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall ensure that discharge letters provide accurate detail of the specific procedure undertaken and/or treatment provided to the patient. Discharge letters provided to all parties should be legible. **Ref: 6.6.1**
	Response by Registered Person detailing the actions taken: • Consultants with practising privileges have been reminded in the current Medical Staff Newsletter of the importance of ensuring the patient discharge letter accurately reflects the procedure(s) undertaken. • A copy of the discharge letter is retained in the patient medical records, and is audited quarterly as part of the Health Record Audit.
Area for improvement 21 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall ensure that comprehensive records are maintained for each patient receiving care and treatment in the hospital: • care plans should be written with the involvement of the patient wherever practicable • care records should provide clear evidence of the care planned, the decisions made, the care delivered and the information shared. (NMC The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, 2018) • all care records should be legible; accurately capture all relevant information; and include the full details of all procedures undertaken **Ref: 6.6.1**

	Response by Registered Person detailing the actions taken: • Staff are allocated named patients for each shift and are responsible for the delivery and documentation of individualised patient care in accordance with the 'Policy on Nursing Documentation and Record keeping' which reflects the requirements of the NMC Code. • Care plans form part of the quarterly health records audit, the results of which are communicated to staff via the hospital meeting structure.

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

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