Announced Enforcement Inspection Report
23 March 2020

Ulster Independent Clinic

Type of Service: Independent Hospital - Acute Hospital
245 Stranmillis Road, BT9 EJH
Tel No:028 9066 1212
Inspectors: Wendy McGregor
and Lorraine O'Donnell

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 provider 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 of 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

4.0 Inspection summary

We undertook an announced desktop inspection of the Ulster Independent Clinic (UIC) on 23 March 2020 from 09:00 hours to 16:00 hours to assess compliance with action points 1(a), 1(h) and 1(i) contained within the extended Failure to Comply (FTC) Notice – FTC000086E issued on 26 February 2020. We did not visit UIC as part of this inspection due to the current impact on all services as a result of COVID-19. We determined that the information we required to confirm compliance could be provided to us electronically and remotely.

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).

On 23 December 2019 RQIA issued a Failure to Comply (FTC) Notice – FTC000086. We undertook an inspection on 24 February 2020 to access compliance with the FTC Notice during which we did not find sufficient evidence to validate full compliance with all of the action points contained within the FTC Notice. We found evidence to validate compliance with action points 1(b), 1(c), 1(d), 1(e), 1(f) 1(g) of the FTC Notice and while significant progress had been made, we were unable to evidence that action points 1(a), 1(h) and 1(i) had been fully addressed.

RQIA senior management held a meeting on 25 February 2020 and a decision was made that the date of compliance for this Notice should be extended. The extended FTC Notice – FTC000086E was issued on 26 February 2020 and the date of compliance with the notice was 23 March 2020.

This inspection sought to assess the level of compliance achieved in relation to action points 1(a), 1(h) and 1(i) of the extended FTC Notice. The areas identified for improvement and compliance with the regulation were in respect to medical governance and specifically arrangements relating to the oversight and management of practising privileges and non-consultant grade doctors operating as surgical assistants.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	9*	10

**Two areas for improvement in relation to medical governance and the Medical Staff Committee were subsumed in to the Failure to Comply Notice issued on 23 December 2019 and were reviewed as part of this inspection.

Nineteen actions required to ensure compliance with the quality improvement plan (QIP) generated as a result of the inspection undertaken between the 22 and 24 January 2019 were not reviewed as part of this inspection and will be carried forward to the next inspection. No new areas for improvement were identified during this inspection.

As a result of the findings of this inspection we determined UIC had achieved compliance with the extended FTC Notice - FTC000086E.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

5.0 How we inspect

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

- the registration status of the establishment;
- written and verbal communication received since the previous inspection;
- notifiable events received since the previous inspection;
- the previous inspection report;
- QIP returned following the previous inspection;
- monthly updates from UIC;
- the FTC notice - FTC000086E; and
- correspondence from The Northern Ireland Medical and Dental Training Agency (NIMDTA).

During our desktop inspection we requested from Ms Diane Graham, Chief Executive/Matron copies of the following records:

- the most recent list of all medical practitioners;
- three theatre registers from 25 February 2020 to 22 March 2020; and
- minutes of a meeting held between UIC and NIMDTA.

We examined the following areas:

- arrangements for medical governance;
- oversight and management of practicing privileges; and
- arrangements for non-consultant grade doctors operating as surgical assistants.

As previously outlined in section 4.1 some areas for improvement identified at the last inspections were not reviewed as part of this inspection and are carried forward to the next inspection.

The findings of the inspection were provided to Ms Graham, Chief Executive/Matron at the conclusion of the inspection by telephone.

6.0 The inspection

6.1 Review of areas for improvement from the last care inspections dated 22, 23, 24 January 2019, follow-up inspection dated 4 November 2019 and enforcement inspection dated 24 February 2020.

This inspection focused on action points 1(a), 1(h) and 1(i) contained within the extended FTC notice -FTC000086E issued on 26 February 2020. Nineteen areas for improvement, from the last inspections on 22, 23 and 24 January 2019, follow-up inspection on 4 November 2019 and enforcement inspection on 24 February 2020 were not reviewed as part of this inspection and are carried forward to the next inspection. The QIP in section 7.2 reflects the carried forward areas for improvement.

6.2 Inspection findings

FTC Ref: FTC000086E

Notice of failure to comply with regulation:

The Independent Health Care Regulations (Northern Ireland) 2005

Fitness of Workers

Regulation 19. – (1) *The registered person shall ensure that –*

(a) no person is employed to work in or for the purpose of the establishment or for the purpose of the agency;
(b) no medical practitioner is granted consulting or practising privileges, unless that person is fit to work in or for the purpose of the establishment, or for the purposes of the agency; and
(c) there is evidence that all professional registration and revaluation requirements are met.

(2) *A person is not fit to work in or for the purposes of an establishment, or for the purposes of an agency unless –*
(a) he is of integrity and good character.
(b) he has the qualifications, skills and experience which are necessary for the work which he is to perform;
(c) he is physically and mentally fit for that work; and
(d) full and satisfactory information is available in relation to him in respect of each of the matters specified in Schedule 2.

(3) *The registered person shall ensure that all healthcare professionals are covered by appropriate professional indemnity.*

In relation to this notice the following nine actions were required to comply with this regulation.

The Registered Person, Chairman of the Medical Staff Committee and Board of Directors must:

1. Implement and assure a live and functioning system for oversight and management of medical governance for all medical practitioners working within the hospital, specifically to ensure that:

    a) a suitable standard operating procedure (SOP) is in place to define the process for application, granting, maintenance and withdrawal of practising privileges in place in the hospital. This procedure should include timescales for each step outlined in the process and ensure there is clarity of expectations and actions;

    b) all medical staff provide the required documentation, as outlined in legislation to maintain their practising privileges agreements, in a timely manner and on an ongoing basis;

    c) there are up to date co-signed practising privileges agreements in place for all medical practitioners working in the hospital, these should be signed by both the doctor and Registered Person and should be reviewed every two years;

d) all medical practitioners granted practising privileges have received a signed up-to-date copy of their practising privileges agreement and understand the standard operating procedure in place in relation to practising privileges, this includes actions the Registered Person and Board of Directors will take should the medical practitioner be non-compliant with the procedure;

e) that all documentation required by legislation is held by UIC for all doctors working in wholly private practice; this includes evidence of mandatory training as advised by RQIA;

f) the practice of using non-consultant grade doctors, under the supervision of Consultants, rather than under a practising privileges agreement or direct employment of UIC ceases with immediate effect and RQIA is provided with urgent written confirmation of this action;

g) a formal determination is made regarding what arrangements will be in place for non-consultant grade doctors operating as surgical assistants in the hospital;

h) robust governance systems and processes are in place to assure the fitness and competence of; i) all medical practitioners working under practising privileges agreements and ii) all non-consultant grade doctors operating as surgical assistants in UIC, including arrangements for supervision and training;

i) non-consultant grade doctors operating as surgical assistants in UIC are doing so through agreed arrangements and that the time spent/service delivered in UIC is in addition to HSC commitments of these doctors.

6.2.1 Medical Governance

We gathered evidence in relation to the three outstanding action points contained within the extended FTC notice - FTC000086E to establish if UIC had complied with the Regulation and implemented and assured a live and functioning system for oversight and management of medical governance for all medical practitioners working within the hospital. We established the following in relation to each action:

Action point 1 a)

A suitable standard operating procedure (SOP) is in place to define the process for application, granting, maintenance and withdrawal of practising privileges in place in the hospital. This procedure should include timescales for each step outlined in the process and ensure there is clarity of expectations and actions.

We reviewed the document titled a “Framework for Medical Governance Policy” which contains the written procedure that defines the process for applying, granting, maintaining, renewing, suspending and withdrawing practising privileges. We also reviewed the following policies (dated March 2020):

- Policy on Retention, Renewal and Withdrawal of Practising Privileges for Non-Consultant Grade Doctors Practising as Surgical Assistants at The Ulster Independent Clinic; and
- Policy on Retention, Renewal, Suspension and Withdrawal of Practising Privileges.

Through discussion with Ms Graham and review of documentation we found that the UIC had revised and shortened the timescales within their practising privileges processes to an acceptable standard.

The practising privileges process allows for medical practitioners to make a self-declaration regarding their scope of practice. To assure themselves UIC will request and scrutinise information, prior to granting or renewing practising privileges, to validate the self-declaration made by each medical practitioner in respect of their scope of practice, examples include the full whole practice appraisal document, letters of good standing and surgical data activity.

Outcome

We found sufficient evidence to determine that this action point had been addressed.

Action point 1 h)

Robust governance systems and processes are in place to assure the fitness and competence of; i) all medical practitioners working under practising privileges agreements and ii) all non-consultant grade doctors operating as surgical assistants in UIC, including arrangements for supervision and training.

We reviewed The Policy on Retention, Renewal and Withdrawal of Practising Privileges (March 2020) and found this policy has been further developed to include clear timeframes for submission of information from individual medical practitioners and the escalation arrangements if information is not received in a timely manner. The policy clearly identifies who is responsible for the oversight of the practising privileges arrangements.

We found that the link between the Medical Advisory Committee (MAC) and Clinical Governance Committee (CGC) had been formalised and their roles and responsibilities clearly defined within the governance structure of the hospital. We reviewed the document titled a "Framework for Medical Governance Policy" and found the role and responsibility of each committee was clearly delignated and in line with the Minimum Standards.

In line with Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments we found that the MAC makes recommendations regarding eligibility for practising privileges. We were informed the MAC would review all evidence presented to them before making a final determination regarding granting or renewing practising privileges and agreeing the medical practitioner's scope of practice in UIC. Ms Graham advised that systems were in place for UIC to scrutinise all supporting documentation received from individual medical practitioners as part of granting, maintaining and renewing practising privileges. A record of who reviewed the supporting documentation, their designation and any action required is recorded as part of the process.

We discussed with Ms Graham how concerns regarding practice are shared with the MAC and the wider HSC. We found that good internal arrangements were in place and the Responsible Officer (RO) for the hospital was linked in the regional RO Network. UIC had developed systems to share the activity data for medical practitioners with practising privileges with other independent providers and the HSC.

We found that the hospital collects data to inform and underpin practising privileges arrangements on a spreadsheet; we reviewed the most recent version of this. The spreadsheet used a traffic light system to alert staff when information was approaching a renewal date. Ms Graham informed of the additional processes which had been implemented in response to our feedback at the previous inspection of 24 February 2020. She advised that daily checks of the practising privileges spreadsheet for Consultants are undertaken by the departmental managers in the outpatients and theatre departments of UIC. This provides an additional level of assurance that all Consultants have complied with the practising privileges arrangements of the hospital before contact with patients. Ms Graham informed us that moving forward a similar spreadsheet for non-consultant grade doctors will be developed and this must also be checked by departmental managers on a daily basis to confirm that the doctors have the appropriate practising privileges arrangements in place.

We were provided with the current list of medical practitioners working in UIC with practising privileges and copies of three theatre registers dating from 25 February 2020 to 22 March 2020. We cross-referenced the current list of medical practitioners with the theatre registers and found the medical practitioners on the registers had the appropriate practising privileges agreements in place.

Outcome

We were assured through discussion with Ms Graham and review of documentation that sufficient progress had been made in to strengthen the medical governance systems within UIC in relation to assuring the fitness and competence of all medical practitioners working under practising privileges agreements and all non-consultant grade doctors operating as surgical assistants in UIC, including arrangements for supervision and training. We found sufficient evidence to determine that this action point had been addressed.

Action point 1 i)

Non-consultant grade doctors operating as surgical assistants in UIC are doing so through agreed arrangements and that the time spent/service delivered in UIC is in addition to HSC commitments of these doctors.

We were informed by Ms Graham that the hospital held a meeting with NIMDTA on 20 February 2020 to agree formal arrangements for non-consultant grade doctors operating as surgical assistants in UIC. We reviewed the minutes of this meeting which confirmed they discussed the arrangements and a representative from NIMDTA had reviewed UIC documents relating to non-consultant grade doctors working as surgical assistants. NIMDTA recommended changes to the documents prior to agreeing the establishment of formal arrangements between UIC and NIMDTA.

RQIA received a letter from NIMDTA dated 23 March 2020 outlining the formal arrangements agreed between UIC and NIMDTA. They confirmed that the governance arrangements that were proposed for postgraduate medical trainees (non-consultant grade doctors) acting as surgical assistants in the UIC would satisfy NIMDTA as the designated body for revalidation of trainees in Northern Ireland.

Outcome

As a formal agreement had been established with NIMDTA we found sufficient evidence to determine that this action point had been addressed.

6.3 Conclusion

We found sufficient evidence was available to validate compliance with action points 1(a), 1(h) and 1(i) contained within the extended FTC notice - FTC000086E.

7.0 Quality improvement plan

There were no new areas for improvement identified during this inspection. The attached QIP contains the areas for improvement carried forward from the last inspections on 22, 23 and 24 January 2019, follow-up inspection on 4 November 2019 and enforcement inspection on 24 February 2020. The nineteen areas for improvement will be reviewed at a subsequent 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 all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the independent hospital. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

No new areas for improvement were identified during this inspection. The attached QIP includes nineteen areas for improvement identified during the last inspections on 22, 23 and 24 January 2019, 4 November 2019 and 24 February 2020.

7.2 Actions to be taken by the service

The Registered Provider is not required to return a completed QIP for assessment by the inspector as part of this inspection process. The QIP reflects the carried forward areas for improvement from inspections on 22, 23 and 24 January 2019, 4 November 2019 and 24 February 2020.

Quality Improvement Plan

Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Minimum Care Standards for Independent Healthcare Establishments (2014)

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.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.

Medical Governance and Medical Staff Committee

Area for improvement 2 **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.

	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Notifiable Events/Incidents	
Area for improvement 3 **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.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Management of Complaints	
Area for improvement 4 **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.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.

Fluid Management	
Area for improvement 5 **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. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.**
Outpatients Department	
Area for improvement 6 **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. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.**

Policy/Guidance and Best Practice	
Area for improvement 7 **Ref:** Regulation 15 (1) (b) **Stated:** Second time **To be completed by:** 4 February 2020	The Registered Person 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: 6.3.3
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
International Dysphagia Diet Standardisation Initiative (IDDSI)	
Area for improvement 8 **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 receives training in relation to the application of the IDDSI guidance which is relevant to their roles and responsibilities.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.

Policy Development/Guidance Documents	
Area for improvement 9 **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).
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Endoscopy/Estates	
Area for improvement 10 **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.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Area for improvement 11 **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.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.

Laser safety	
Area for improvement 12 **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.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Area for improvement 13 **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.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Area for improvement 14 **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.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Area for improvement 15 **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.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.

Medicines Management	
Area for improvement 16 **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.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Care Pathway	
Area for improvement 17 **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.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Area for improvement 18 **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.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.

Area for improvement 19 **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
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.

The Regulation and Quality Improvement Authority

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

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews