Unannounced Enforcement Inspection Report
24 February 2020

Ulster Independent Clinic

Type of Service: Independent Hospital - Acute Hospital
245 Stranmillis Road, BT9 EJH
Tel No:028 9066 1212
Inspectors: Jo Browne, Wendy McGregor, John Simpson, Stephen O'Connor 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 unannounced inspection to the Ulster Independent Clinic (UIC) on 24 February 2020 from 09:00 hours to 17:00 hours.

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. This inspection sought to assess the level of compliance achieved in relation to the FTC Notice. The areas identified for improvement and compliance with the regulation were in relation to medical governance and specifically arrangements relating to the oversight and management of practising privileges and non-consultant grade doctors operating as surgical assistants. The date of compliance with the Notice was 23 February 2020.

We did not find sufficient evidence to validate full compliance with the above FTC Notice. However, we found evidence of some improvement and progress made to address six of the nine required actions within the Notice. 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. Compliance with this notice must therefore be achieved by 23 March 2020. The extended FTC Notice – FTC000086E was issued on 26 February 2020.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	11*	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.

Ongoing enforcement action resulted from the findings of this inspection. As a result of the findings of this inspection the date of compliance with the FTC Notice: ref: FTC000086 was extended to 23 March 2020.

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; and
- the FTC notice

During our inspection we met with Ms Diane Graham, Chief Executive/Matron, members of the senior management team, the Governance Review Consultant, the Theatre Manager and theatre staff.

We examined the following areas:

- progress made in relation to UIC's review of its overarching governing systems;
- arrangements for medical governance/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 care inspection 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 and members of the senior management team at the conclusion of the inspection.

6.0 The inspection

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

This inspection focused on the actions contained within the FTC notice (FTC000086) issued on 23 December 2019. Nineteen areas for improvement, from the last care inspection on 22, 23 and 24 January 2019 and follow-up inspection on 4 November 2019 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: FTC000086

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 doctor.

6.2.1 Governance Review

We reviewed the progress made in relation to the governance review being undertaken by UIC. We found that a Governance Review Consultant had been appointed and had taken up post. We were informed that the governance review had been completed and an action plan had been generated to progress the recommendations identified as part of the review. The action plan was shared with the Chairman of the Board of Directors on 31 October 2019. We were advised by the senior management team that the Governance Review Consultant was providing ongoing support to the governance department within UIC to implement the recommendations identified in the action plan. As the recommendations of the governance review had not yet been fully implemented this will be further reviewed at the next inspection.

We were provided with an overview of the governance structures within the hospital and we discussed the role and function of each committee with the senior management team. We were advised that links had been established with other independent health care providers and The Northern Ireland Medical and Dental Training Agency (NIMDTA) to support the ongoing work of the governance review. Ms Graham advised the Independent Healthcare Providers Network (IHPN) "Framework for Governance" document was used as a reference tool to inform their decision making.

We found that the Clinical Governance Committee (CGC) had undertaken a more enhanced role within the revised governance structure and we were advised that the Chairperson of the Medical Advisory Committee (MAC) attended the CGC meetings. We reviewed minutes of the CGC and MAC and we were unable to identify a formal link in the governance structure for the sharing of information between these two committees. We advised that this link should be strengthened and clearly outlined within the terms of reference and the minutes for both committees. The role and responsibility of each committee must be clearly delignated and in line with the Minimum Standards.

6.2.2 Medical Governance

We gathered evidence in relation to the nine action points outlined in the Failure to Comply Notice 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" (dated February 2020) which has been ratified by the Clinical Governance Committee and the Chair of the Medical Advisory Committee. We identified some areas which required to be strengthened in relation to the management of practicing privileges and in particular assessing if a medical practitioner's scope of practice in UIC was in line with their NHS practice. Within the document it states that the responsibility lies with the individual medical practitioner to declare their individual scope of practice.

We did not find that robust arrangements were in place for UIC to assure themselves of each individual medical practitioner's NHS scope of practice prior to granting or renewing practising privileges.

Outcome

We found that this action point had not been fully addressed and further improvement is required in relation to developing a robust SOP in relation to practising privileges.

Action point 1 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*.**

The only mechanism for a clinician to work in a registered independent hospital is either under a practising privileges agreement or through direct employment by the hospital. Practising privileges can only be granted or renewed when full and satisfactory information has been sought and retained in respect of each of the records specified in Regulation 19 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended.

We spoke with the senior management team and the Governance Review Consultant who described the arrangements in place for granting, maintaining, renewing, suspending and withdrawing practising privileges. We reviewed how UIC ensures that they receive all of the required documentation from each individual medical practitioner in relation to practising privileges. We found that the hospital collects data to inform and underpin practising privileges arrangements on a spreadsheet; and we reviewed the most recent version of this spreadsheet. We were informed that administrative staff updated the information on the spreadsheet and any delays in receiving information from medical practitioners were escalated to Ms Graham.

We were informed that three medical practitioners who had not provided the required documentation have had their practising privileges agreements suspended.

Outcome

We were assured through discussion with the senior management team and review of documentation that sufficient progress had been made in relation to gathering information underpinning practising privileges arrangements and the actions taken to suspend practising privileges for individual medical practitioners who did not furnish UIC with the required information. This action point has been addressed.

Action point 1 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.

We discussed the process for signing and issuing of practicing privileges agreements with Ms Graham, Chief Executive/Matron. Ms Graham confirmed that all medical practitioners granted practising privileges had received a signed up-to-date copy of their agreement.

We reviewed the practising privileges agreements of 12 medical practitioners and confirmed they were up to date and had been signed by a representative of UIC and the medical practitioner.

Outcome

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

Action point 1 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.

Ms Graham, Chief Executive/Matron advised that all medical practitioners had been issued a copy of the revised practising privileges SOP, via email, which included the action UIC will take for non-compliance with the procedure. As previously stated, we were able to evidence that UIC had taken action to suspend the practising privileges of three medical practitioners who had not complied with their procedures.

Outcome

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

Action point 1 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.

We reviewed the systems in place to manage the granting, maintaining, renewal, suspending and withdrawal of practising privileges and mandatory training for doctors working in wholly private practice. As discussed under Action point 1 b), we found that arrangements were in place to gather the documentation required by legislation for this group of doctors.

We found that training records were available to confirm that doctors working in wholly private practice had completed the required mandatory training at the time of inspection. We identified, however, that the training frequency which had been set by UIC was not in keeping with training requirements as advised by RQIA and going forward this could lead to training not being updated in a timely manner. The senior management team provided assurances that they would amend the frequency of training and advise all doctors working in wholly private practice of the revised timescales.

Outcome

We found sufficient evidence and were assured through discussions that this action point had been addressed.

Action point 1 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.

We received confirmation on 10 January 2020 that 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 had ceased.

We discussed the use of surgical assistants with the senior management team, theatre manager and theatre staff. We reviewed the theatre registers from 23 December 2019 to the date of this inspection to confirm that the practice of using non-consultant grade doctors had ceased.

We found that where the use of a surgical assistant was required to facilitate a complex surgical procedure, Consultants who had previously been granted practising privileges by the hospital assisted in the operation to ensure that patient safety for this type of procedure was not comprised. We cross referenced the names recorded as surgical assistants in the theatre registers against the list of Consultants granted practising privileges and found that no non-consultant grade doctors had been used during the period we reviewed. We were able to evidence that the use of non-consultant grade doctors operating as surgical assistants had ceased on 3 January 2020 and that sufficient safeguards were in place to protect the safety and wellbeing of patients.

Outcome

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

Action point 1 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.

We were informed that UIC have made a formal determination that non-consultant grade doctors operating as surgical assistants in the hospital will do so under a practising privileges agreement that clearly defines their scope of practice while working in UIC. We were advised that non-consultant grade doctors will be provided with an induction in theatre and can only operate under the direct supervision of a Consultant who also has been granted practising privileges.

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 (December 2019) and found that it did not include appropriate timeframes relating to renewal and withdrawal of practising privileges and did not indicate who is responsible for oversight of these arrangements. We provided advice on further developing this policy 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. We also advised that the policy must clearly identify who is responsible for the oversight of the practising privileges arrangements.

Through discussion with the senior management team we were informed that when a letter requesting to apply for practising privileges is received by UIC this is pre-approved by the MAC without them seeing the full application and supporting documentation. An application pack is forwarded to the applicant and the CGC review the completed application and supporting documentation and confirm that practising privileges should be granted. The confirmed application does not go back to the MAC for final approval. Under Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments it is the role of the MAC to make recommendations regarding eligibility for practising privileges. The MAC can devolve the task of reviewing the application and supporting documentation to the CGC; however the accountability remains with the MAC and the final decision must be made by them and recorded in their minutes. As previously stated under section 6.2.1 the link between the MAC and CGC should be formalised with their roles and responsibilities clearly defined within the governance structures of the hospital.

We advised that robust systems should be in place to scrutinise all supporting documentation received from individual medical practitioners as part of granting, maintaining and renewing practising privileges. UIC should base their decision on evidence received from other organisations, e.g. letters of good standing, activity data, appraisal documentation and not rely on self-declarations from individual medical practitioners. We suggested that UIC requests the full appraisal for each medical practitioner, as this can provide invaluable insight into the medical practitioner's practice and not the sign off sheet alone. A record should be retained of who reviewed the supporting documentation, their designation, any action required and when this was shared with the MAC for final approval. The MAC should review all evidence presented before making a final determination regarding granting or renewing practising privileges and agreeing the medical practitioner's scope of practice in UIC. We evidenced that the scope of practice for each individual practitioner is clearly defined by speciality and then again by sub speciality and we consider this to be good practice.

We were provided with a list of 391 medical practitioners working in UIC with practising privileges; however we found that that this list was not accurately maintained. We identified three medical practitioners who were working in the hospital between the FTC Notice being issued on 23 December 2019 and the inspection who were not included on the list of medical practitioners provided to us. We were able to evidence following the inspection that the identified medical practitioners had the appropriate practising privileges agreements in place at the time of inspection and that it was a clerical oversight that the list provided to us had not

been updated. We advised that the system in place for overseeing the management practising privileges must be accurately maintained at all times to provide the required level of assurance to senior management team of UIC.

We were advised that the departmental managers had access to the up to date practising privileges spreadsheet through their individual computer desktops. We spoke with departmental managers who advised that they did not refer to this document routinely to assure themselves that medical practitioners were compliant with practising privileges arrangements and relied on emailed updates from the Governance Review Consultant to advise them of any changes. We advised that the system should not be reliant on one individual sending updates and going forward UIC must strengthen how this information is shared with and checked by departmental managers.

As outlined under action points 1 f) and 1g) UIC has ceased the use of non-consultant grade doctors operating as surgical assistants in UIC and has made the determination this group of doctors will operate under a practising privileges agreement with a limited scope of practice once full compliance with the FTC has been achieved. We were informed that the hospital were meeting with The Northern Ireland Medical and Dental Training Agency (NIMDTA) following the inspection to discuss and agree arrangements for supervision and training of non-consultant grade doctors. NIMDTA is responsible for funding, managing and supporting postgraduate medical and dental education within the Northern Ireland Deanery. Ms Graham advised that she would update RQIA on the outcome of the meeting.

We discussed with senior management 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 discussed governance in relation to medical practitioners who consult with patients in the outpatient's department of UIC and how oversight of this work can be captured under the governance structures of the hospital. We advised that, to assure themselves of good medical practice, UIC should develop a system to randomly select and audit/peer review the medical records of outpatients by someone with the knowledge and skills to identify if there were any concerns.

We found that a set of quality indicators had been developed and these were reported to and reviewed by the CGC, examples included complaints, incidents, activity data and performance.

Outcome

While UIC had made significant progress, further work is required 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 could not evidence that this action point had been fully 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.

As previously stated in action point 1 h) we were informed that the hospital were meeting with NIMDTA following the inspection to agree arrangements for non-consultant grade doctors operating as surgical assistants in UIC and RQIA will be updated on the outcome of the meeting.

Ms Graham provided us with an update on some initial discussions that had taken place between UIC and NIMDTA. She advised of plans for non-consultant grade doctors to sign a declaration as part of their practising privileges application to confirm that they were not working in UIC on HSC time. A log book would be retained for each doctor and their name recorded as the surgical assistant in the theatre registers. Collation of this information will enable UIC to provide a record of activity for each non-consultant grade doctor to their HSC employer as and when required.

Outcome

As no formal agreement had been established with NIMDTA at the time of this inspection we were unable to gather sufficient evidence to determine that this action point had been addressed.

6.3 Conclusion

We found evidence was available to validate compliance with action points 1(b),1(c),1(d), 1(e), 1(f) 1(g) of the Failure to Comply Notice. While significant progress had been made by UIC we were unable to evidence that action points 1(a), 1(h) and 1(i) had been fully addressed. The Failure to Comply Notice was extended and must be complied with by 23 March 2020.

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 inspection on 22, 23 and 24 January 2019 and the follow-up inspection on 4 November 2019. 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; all others 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.

7.2 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 and 4 November 2019.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Minimum Care Standards for Independent Healthcare Establishments (2014)</th></tr>
<tr><th colspan="2">Clinical and Organisational Governance</th></tr>
<tr><td>Area for improvement 1

Ref: Regulation 17

Stated: First time

To be completed by:
9 February 2020</td><td>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.</td></tr>
<tr><td></td><td>Action required to ensure compliance with this regulation was partially reviewed as part of this inspection and full review will be carried forward to a subsequent inspection.</td></tr>
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Medical Governance and Medical Staff Committee	
Area for improvement 2 **Ref:** Regulation 19 **Stated:** Second time **To be completed by:** 23 February 2020	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.
	Action required to ensure compliance with this regulation was reviewed and progressed as part of the Failure to Comply Notice (FTC) issued on 23 December 2019. The date of the compliance with the FTC notice has been extended as a result of this inspection and compliance must be achieved by 23 March 2020.
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.
	Action required to ensure compliance with this regulation was reviewed and progressed as part of the Failure to Comply Notice (FTC) issued on 23 December 2019. The date of the compliance with the FTC notice has been extended as a result of this inspection and compliance must be achieved by 23 March 2020.

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.
	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 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.
	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 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.
	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 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.

	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 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.
	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 9 **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 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.
	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 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).
	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 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.
	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**: 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 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. **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 48.6 **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 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. **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 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. **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 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. **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 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. **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 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.
	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 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
	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.

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