The Regulation and Quality Improvement Authority

Inspection Report

1 November 2021

Ulster Independent Clinic

Type of Service: Independent Hospital (IH)
Ulster Independent Hospital
245 Stranmillis Road
Belfast
BT9 5JH

Tel No: 028 9066 1212

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/ The Independent Health Care Regulations (Northern Ireland) 2005 and Minimum Care Standards for Independent Healthcare Establishments (July 2014)

1.0 Service information

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
Brief description of the accommodation/how the service operates: The Ulster Independent Clinic (UIC) 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.	

2.0 Inspection summary

An unannounced inspection was undertaken to the Ulster Independent Clinic on 1 November 2021 and concluded on 11 November 2021 with feedback to the manager, Ms Diane Graham and members of the senior management and governance teams.

The hospital was inspected by a team comprised of care inspectors, a medical practitioner and an estates inspector.

This inspection focused on eight key themes: governance and leadership; patient care records; surgical services/theatres; nursing care; safeguarding; staffing; environment and IPC; and estates. The inspection also sought to assess progress with any areas for improvement identified within the quality improvement plan (QIP) from the last inspection to UIC on 17 and 18 November 2020.

We met with a range of staff, including managers, nursing and medical staff, catering staff, domestic services staff and allied health professionals (AHPs). We reviewed aspects of frontline care and practices and the management and oversight of governance across the organisation.

It was established UIC have robust governance and oversight mechanisms to provide assurances relating to medical and clinical governance, management of incidents and care delivery. There was evidence of effective communication systems to ensure staff and patients received key information. It was noted staffs knowledge was good in relation to safeguarding, the World Health Organisation (WHO) surgical checklist, and the assessment and management of pain.

Patients told us they were happy with the care and advice/guidance provided to them by the hospital staff.

It was noted a number of quality improvement initiatives were in progress; one of which was the development of an e-learning platform to facilitate improved compliance with staffs mandatory training.

Six areas for improvement (AFI) identified during previous inspections were reviewed and an assessment of achievement was recorded as met for each.

An area for improvement was identified regarding the introduction of malnutrition screening to include the use of a malnutrition-screening tool in line with National Institute for Health and Care Excellence (NICE) Clinical Guidance CG32 and corresponding training for staff.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure

compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

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

- the registration status of the establishment;
- written and verbal communication received since the previous inspection;
- the previous inspection reports;
- QIPs returned following the previous inspections;
- notifications;
- information on concerns;
- information on complaints; and
- other relevant intelligence received by RQIA.

Inspectors assessed practices and examined records in relation to each of the areas inspected and met with the registered manager, members of the multidisciplinary team (MDT) and the senior management and governance team.

Experiences and views were gathered from staff, patients, and their families.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

4.0 What people told us about the service

Posters informing patients, staff and visitors of our inspection were displayed while the inspection was in process. Staff and patients were invited to complete an electronic questionnaire during the inspection.

Two patient questionnaires were received by RQIA during the inspection. The feedback from patients indicated that they were satisfied with their care and treatment.

Several interviews with medical, nursing and catering staff were conducted. These interviews included staff from two wards, theatres and the Out Patients Department (OPD). No staff questionnaires were received by RQIA.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to UIC was undertaken on 17 and 18 November 2020 by a team of inspectors; three new areas for improvement were identified and three areas for improvement were stated for a second time.

Areas for improvement from the last inspection on 17 and 18 November 2020		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Minimum Care Standards for Independent Healthcare Establishments (2014)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 17.1 **Stated:** First	The Registered Person shall ensure that the COVID-19 risk assessments for the staff restaurant kitchen area and wards are updated to reflect the social distancing measures to be implemented in each area.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail provided in section 5.9.	
Area for improvement 2 **Ref**: Standard 19 **Stated:** First	The Registered Person shall ensure they: • develop and maintain a robust system for ensuring that IPC audits are completed and outcomes actioned at appropriate intervals; and • ensure the results of these audits are available and displayed for staff, patients and visitors to provide assurance of compliance with IPC measures.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail provided in section 5.9.	

Area for improvement 3 **Ref**: Regulation **Stated:** First	The Registered Person shall ensure that: • there are effective and robust processes in place to analyse data, specifically in relation to incidents/accidents and patient satisfaction surveys; and • action plans should be created to address any deficits noted as result of the analysis of data and include actions that are specific, measurable, achievable, realistic and time bound (SMART).	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail provided in section 5.3.1.	
Area for improvement 4 **Ref**: Regulation 21 **Stated:** Second	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 patient's medical history, all treatment provided, and all notes prepared by other health care professionals involved in their care.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail provided in section 5.4.	

Area for improvement 5 **Ref**: Regulation 19 **Stated:** Second	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).	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail provided in section 5.3.3.	
Area for improvement 6 **Ref**: Regulation 21 (1) **Stated:** Second	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.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail provided in section 5.4.	

5.2 Inspection findings

5.3 Governance and Leadership

5.3.1 Clinical and Organisational Governance

There was a clear organisational structure within the hospital and staff were able to describe their roles and responsibilities. Staff confirmed that there were good working relationships with managers who were responsive to any suggestions or concerns raised.

The hospital has a defined clinical governance structure in place with regular meetings which included the Clinical Governance Committee, Medical Advisory Committee (MAC), and Practice Development Group. A monthly governance report is compiled by the Quality and Education (Q & E) team and presented to the Clinical Governance committee each month. These reports include information on staffing and staff management, medical staff practising privileges status, NMC registration status, mandatory training, staff absence, corporate risk register, audits, clinical incidents and complaints and patient experience. Action plans were created to address any deficits in performance. These action plans were specific, measurable, achievable, realistic, and time bound (SMART) and have led to a number of practice changes. Additionally, the Clinical Governance committee in conjunction with the MAC meet on a monthly basis to identify appropriate topics for medical audit and oversee the implementation of these audits. Minutes of MAC meetings were retained and were available for inspection. It was determined that the previous area for improvement 3 outlined in section 5.1 was met.

Systems were in place to ensure that the quality of services provided by the hospital is evaluated on an ongoing basis. Regular audits undertaken included; audits of venous thromboembolism (VTE) risk assessments, Infection Prevention and Control (IPC), surgical safety checklists, fluid balance charts, and prescription charts. A clear system was in place that addressed areas of non-compliance

There was evidence of monthly ward staff meetings. These meetings are held on a Sunday when there is a downturn in activity however this has the potential to impact on the ability of all staff to attend. This was discussed with the manager who agreed to consider the use of video conferencing to improve access. The manager also discussed introducing standing agenda items and rotating the chair and minute taker responsibilities to provide development opportunities for staff.

5.3.2 Practising Privileges

The hospital has a policy and procedure in place, which outlines the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges. There are systems in place to review practising privileges agreements every two years. The inspection team found that hospital management maintained a robust oversight of arrangements relating to practising privileges. We reviewed several personnel files of consultants operating during the course of the inspection, and found that all relevant documentation was present in relation to professional indemnity, insurance and medical appraisals for these doctors.

5.3.3 Communication

Policies and procedures were available for staff reference and they were dated and systematically reviewed. Staff told us they were aware of the policies and how to access them.

A procedure for the Dissemination and Implementation of Regional and National Guidance, urgent communications, safety alerts, and notices was available to ensure all patient safety communications received, were distributed and actioned appropriately in a timely manner. The Quality and Education (Q & E) team, Clinical Governance Committee and the Practice Development Group review circulars and guidance and action appropriately to ensure compliance with recommendations. Decisions made following these reviews were included in the minutes of each of these groups' meetings.

Staff advised that the introduction of a 'Governance Matters Newsletter, has proven to be valuable tool to communicate information to staff when the normal schedule of meetings has been disrupted during the Covid-19 pandemic. This newsletter is shared with staff bi monthly and provides an overview of key information in a comprehensive and user friendly format.

Staff additionally told us that the communication of information is also supplemented at staff meetings, by email, and also by information displayed for staff information boards. It was determined the previous area for improvement 5 was met as outlined in section 5.1.

5.3.4 Complaints Management

Copies of the complaints procedure and whistleblowing policy were available and staff demonstrated a good awareness of both. Information recorded for complaints included nature, type of complaint, department involved, clinical speciality involved, risk rating, outcome and complainant satisfaction and whether response timescales were met. There was clear evidence of the introduction of learning and changes from complaint analysis. It was noted that completed patient satisfaction surveys were reviewed and any issues/suggestions identified by patients were actioned.

5.3.5 Notifiable Events/Incidents

Systems were in place to support good risk management within the hospital. This ensures that the chances of adverse incidents, risks and complaints are minimised by effective risk identification, prioritisation, treatment and management.

The hospital has introduced a new electronic adverse incident reporting system. The new system enables the quick analysis of incident data and provides actionable trend intelligence that can be reported in real-time, reducing delays experienced with the previous paper based system. In addition, a new Serious Adverse Incident (SAI) tool kit has been developed to assist in the investigation of SAIs.

A monthly summary of adverse clinical risks are presented as part of the governance report to the clinical governance committee. A summary of all adverse incidents along with learning from incidents form part of the Governance Matters Newsletter. Information relating to events/incidents was provided to RQIA, in line with the legislation, within appropriate timeframes.

Examination of insurance documentation confirmed that insurance policies were in place.

The RQIA certificate of registration was up to date and displayed appropriately.

5.4 Patient Care Records (medical and nursing)

The hospital was registered with the Information Commissioner's Office (ICO). Records required by legislation were retained and were available for inspection at all times.

Review of a sample of patient records evidenced they included a contemporaneous note of each patient's medical history, medicine regime, all treatment provided, and notes prepared by other health care professionals involved in their care. Care records contained information relating to pre-operative, peri-operative, and post-operative care which clearly outlined the patient pathway. There were some concerns relating to the legibility of clinical notes and the recording of General Medical Council (GMC) numbers alongside entries in line with GMC good practice advice. This was brought to the attention of the manager during feedback and they provided assurances this would be addressed and included within the ongoing documentation audits.

A register of all patients attending the Out Patient Department (OPD) was retained, and records of the consultations were noted in the patients' records. It was noted that patients were assessed by the consulting surgeon to determine their suitability for the surgery. Whilst an assessment tool was not evident, a copy of the assessment information was available for ward staff as part of the admission process. A pre-admission nurse assessed patients, who required an overnight stay following surgery. Staff told us that during the pre-assessment, the patients' medication was checked and if any concerns were noted, the patients' general practitioner (GP) was contacted for confirmation of their medication prescription. There was evidence of ongoing review and audit of the admission process as part of the theatre cancellation audit. It was determined the previous areas for improvement 4 and 6 were met as outlined in section 5.1.

Nursing care records were found to be patient centred and care plans evidenced that patient needs were reviewed and met. Care records provided clear evidence of the care planned, the decisions made and the care delivered.

Patient care records were held in a secure environment. Computerised records were accessed using individual usernames and passwords. Staff told us of the challenges in accessing clinical information as result of the hospital not having access to the NI Electronic Care Record (NIECR) system. RQIA have raised this concern with the Health and Social Care Board.

5.5 Surgical Services/Theatres

A review of surgery arrangements evidenced the theatres were operating effectively.

Staff told us that when scheduling theatre lists, the individual requirements of the patient; type of procedure performed; availability of equipment; staffing levels required; associated risks; and level of sedation used were all taken into account.

There was evidence that there was an identified member of nursing staff, with theatre experience, in charge of the operating theatre at all times and a permanent record was maintained, detailing the name of the nurse in charge of each theatre session. Review of a

variety of documents and theatre records, which included the register for all surgical assistants log, and staff induction booklets, evidenced they did not consistently contain full names/signatures of staff. These issues were brought to the attention of the nurse in charge of theatres and they provided assurances this issue would be addressed.

Work had progressed with HSC Trusts in relation to the submission of patient consented data to be included in on The Breast and Cosmetic Implant Registry (BCIR). This register was established to enable the identification of trends, complications relating to implants, and to ensure patients could be traced in the event of a product recall or other safety concern. An agreed action plan was due to be completed in the near future.

Supplies of sterile instrument packs were obtained from the onsite sterile services department. Robust measures were in place to monitor the traceability of all surgical instruments used in the hospital. It was noted clinical equipment in use and stored was clean and fit for purpose and traceability labels were used to identify when pieces of equipment had been cleaned.

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

Staff and patients confirmed that the relevant Consultant Anaesthetist visited each patient prior to surgery, to; assess their general medical fitness; review their medication; explain the type of anaesthetic; discuss the procedure, obtain informed consent, and discuss options for post-operative pain relief. A review of a sample of patient records evidenced these visits by the Consultant Anaesthetists. It was noted Consultant Anaesthetists were present throughout the patient's surgery and on-site until the patient had recovered from the immediate effects of their anaesthetic.

Patients were observed during surgery and in the recovery room and the hospital had discharge criteria in place to ensure patients were well enough to leave theatre recovery and to transfer to the ward area.

5.6 Nursing Care (nutrition and hydration, pain management and compassion)

Patients had a good choice of meals and were able to request snacks, a choice of fluids, and smaller meal portions using the menu provided by the hospital. Meal times were protected and patients were monitored during meal times to ensure they received any required assistance. Care records evidenced patient daily fluid intake was recorded where required. There were no patients that required food intake monitoring at the time of the inspection. Patient feedback was excellent in relation to food quality and menu choices.

There were communication systems in place between nursing staff and catering staff that ensured individual patient dietary needs, including allergies and requirements for a modified texture diet, were shared. It was noted that whilst shared written documentation between nursing staff and catering staff allowed for the identification of patient dietary texture requirements, however, this did not include fluid consistency requirements. This was highlighted to the Q&E Team at the time of the inspection and assurance was provided that this would be reviewed with ward managers and subsequently incorporated into the relevant documentation.

The Q&E Team had conducted a gap analysis of the hospital's practices in relation to a Safety and Quality Reminder of Best Practice Guidance Letter 'Risk of serious harm or death from choking on foods', issued by HSCB in February 2021and reissued June 2021. Following this gap analysis an action plan was developed outlining the need to identify further training needs for staff, the need to update nursing care planning records and consideration required to the implementation of a safety pause before meal/snack times. This will further strengthen patient safety and effective communication for patients with swallowing difficulties.

Weight, height, and body mass index (BMI) were recorded within the patients' care records. It was noted a malnutrition screening tool was not used to identify malnutrition and those at risk of malnutrition. An area for improvement has been identified to improve this area of care for patients in line with NICE recommendations[1].

There were good patient pain management records and it was identified by staff as a key priority post-surgery. Nursing staff demonstrated a good knowledge of assessment and ongoing review of pain management. Staff told us of excellent links with the MDT to optimally manage this area of care for patients.

Interactions between patients and staff were observed throughout the hospital and clearly evidenced patients were treated with compassion, dignity and respect. Consultation rooms and individual patient bedrooms were available in the hospital that facilitated patients to meet privately with medical practitioners whilst maintaining privacy and confidentiality.

5.7 Safeguarding

We reviewed arrangements for safeguarding of children and adults. Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. Policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child.

Staff 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 matrix evidenced that all relevant staff had received training in safeguarding children and adults and safeguarding leads had received training at a level appropriate to their role.

A whistleblowing/raising concerns policy was available which provided 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.

5.8 Staffing (recruitment and selection, training, supervision and appraisal).

Staffing arrangements were reviewed within the hospital. Discussion with Ms Graham confirmed a number of staff of various grades and professions had been recruited since the previous inspection. A random sample of five personnel files, which included newly recruited staff,

[1] NICE Clinical Guidance CG32.

demonstrated that the information required by legislation had been sought and retained through the recruitment and selection process.

A review of duty rotas and discussion with staff evidenced that there were sufficient staff in various roles to fulfil the needs of the hospital and patients. There was 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) was also available on site to provide medical cover and support nursing staff seven days a week, including out of hours cover.

The ward manager confirmed that staff were rostered to meet the needs of patients and a number of bank nurses, who have experience working in the hospital, were available to ensure that adequate staffing levels were maintained. Staffing levels and morale on the wards were good and there was evidence of multidisciplinary working and good communication between staff. Staff told us that they were happy, felt supported and that there were good working relationships throughout the hospital.

Induction programme templates were in place relevant to specific roles within the hospital. A sample of two evidenced that induction programmes had been completed when new staff joined the hospital.

Review of the training matrix evidenced that mandatory training was not up to date in all departments, and in particular theatres; this had been identified by the hospital and was included on the risk register. Action had been taken to improve compliance with staff training and there were oversight mechanisms in place to monitor progress. The ability to access training, in particular face to face training, had been impacted by Covid-19 restrictions.

The hospital Q&E team in conjunction with staff from the Information Technology team had developed an e-learning platform to assist in improving accessibility to and compliance with training; and was due to be available to staff in mid-November 2021.

Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place. Staff told us they felt supported and involved in discussions about their personal development. Records evidenced one hundred per cent of ward staff appraisals had been completed on an annual basis. It was noted staff did not regularly receive professional/clinical supervision, the hospital's policy stated supervision was available and completed on a voluntary basis. Supervision is an important part in professional development and we advised that staff complete supervision in line with their professional bodies' guidance/best practice and retain a written record as evidence for inspection purposes. The hospital's supervision policy should be reviewed to reflect this.

There was a process in place to review the registration details of all health and social care professionals with their professional bodies. Discussion with the manager and review of documentation evidenced that doctors who deliver services in the hospital provide evidence of the following:

- confirmation of identity;
- current registration with the General Medical Council (GMC);
- appropriate professional indemnity insurance;
- appropriate qualifications, skills and experience;

- ongoing professional development and continuing medical education that meet the requirements of the Royal Colleges and GMC; and
- ongoing annual appraisal by a trained medical appraiser.

Review of records evidenced that a robust system was in place to review the professional indemnity status of all staff that require individual indemnity cover. Personnel files confirmed that medical practitioners had appropriate professional indemnity insurance in place. A key element in the revalidation process for medical staff is annual appraisal. It was noted a number of doctors annual appraisals had not been completed, however as part of the Department of Health (DOH) Covid-19 response the DOH waived this contractual obligation, consequently, appraisals were suspended until further notice, unless there are exceptional circumstances. Where appraisals had not been completed, due to the impact of Covid-19, this was clearly recorded in the medical practitioner's personnel file and systems were in place to keep this under review.

Staff told us Trust patients received care and support from visiting health care professionals such as breast care, and colorectal nurse specialists from the Trust. Staff were not always aware when these specialist nurses were scheduled to visit and there was a lack of oversight and governance arrangements in place for this small group of staff. This was brought to the attention of the manager and was immediately addressed. Contact was made with the Trust and letters of good standing were requested from the individuals employing Trust. During the inspection they successfully obtained these for two of the three staff identified and were awaiting a response from a Trust in relation to the third.

5.9 Environment and IPC

The standard of environmental cleaning of clinical and non-clinical areas throughout wards and departments was good. All areas were free from clutter.

A range of documentation was reviewed, including minutes of meetings; risk assessments; staff training records, hand hygiene, and environmental audits. Staffs' Infection Prevention and Control (IPC) practices were observed to be good, for example, hand hygiene and compliance with the use of personal protective equipment (PPE). IPC audits were completed monthly and were completed by a range of staff. The results of these audits, and related action plans, were displayed and shared with staff. The results of key performance indicators were also displayed for patients and visitors to provide assurances with IPC measures. It was determined the previous area for improvement 2 was met as outlined in section 5.1.

Covid-19 general risk assessments were completed; the Covid-19 risk assessments for the staff restaurant kitchen area and wards were updated to reflect the social distancing measures to be implemented in each area. Information to guide staff, patients and visitors on the Covid-19 measures to be taken was displayed in each area. It was determined the previous area for improvement 1 was met as outlined in section 5.1.

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 contents and temperatures were checked. The emergency trolleys were accessible and their contents checked at regular intervals to ensure that equipment was in working order and perishable items were in date.

5.10 Estates

Documentation in relation to the maintenance of the premises, including mechanical and electrical services, was reviewed. Discussion with the Estates Manager, and estates staff evidenced that suitable arrangements were in place for maintaining the environment in accordance with current legislation and best practice guidance. The following documents were reviewed:

- the Fire Risk Assessment;
- service records for the premises fire alarm and detection system;
- service records for the premises emergency lighting installation;
- service records for the premises portable fire-fighting equipment;
- records relating to the required weekly and monthly fire safety function checks;
- records of fire drills undertaken;
- Lifting Operations and Lifting Equipment Regulations (LOLER) 'Thorough Examination' reports of the premises' lifts and patient lifting equipment;
- condition report for the premises' fixed wiring installation;
- condition report for the formal testing of the premises' portable electrical appliances;
- the Legionella Risk Assessment;
- service records and validation checks for the premises specialist ventilation systems, and medical gases pipeline services; and
- service records for the premises space heating boilers and emergency standby electrical generator.

The specialised ventilation systems and medical gas pipeline services were serviced and maintained in accordance with current best practice guidance. Suitable validation was undertaken in accordance with the current Health Technical Memoranda. Records and validation reports were available and reviewed at the time of the inspection.

The most recent Legionella Risk Assessment was undertaken on 6 May 2021. Suitable control measures for the premises hot and cold water systems were in place with appropriate records maintained. A full chemical treatment of the hot and cold water systems was undertaken annually. Regular bacteriological sampling of the hot and cold water systems was also regularly undertaken and appropriate action was taken when necessary.

The most recent Fire Risk Assessment had been undertaken on 9 November 2021 by a suitably accredited fire risk assessor. This report had not yet been issued. The significant findings stemming from the previous fire risk assessment had been addressed and signed-off appropriately within the recommended time scales. The overall risk rating for the premises was therefore assessed as 'Tolerable'. Staff told us suitable fire safety training was delivered and staff demonstrated that they were aware of the action to be taken in the event of a fire.

Details relating to the decontamination process for flexible endoscopes within the clinic were reported on separately in a recent specialist inspection report 'IN039597', issued on 30 September 2021.

The overall environment including the entrance, reception, wards, theatres, treatment rooms, and consultation rooms were maintained to a high standard of décor.

6.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005.

	Regulations	Standards
Total number of Areas for Improvement	1	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Diane Graham, the manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 15 (1) **Stated:** First **To be completed by:** 11 Dec 2021	The Registered Person shall: • Introduce malnutrition screening, to include the use of a malnutrition screening tool, in line with NICE Clinical Guidance CG32 and corresponding training for staff Ref**:** 5.6
	Response by registered person detailing the actions taken: NICE Clinical Guidance CG32 has been discussed at the Practice Development Group meeting. The malnutrition screening tool (MUST) will now form part of patient assessment and ongoing care with details being recorded in each patient's careplan. Training for staff is being actioned in conjuction with the Clinic's dietitian.

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

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