Announced Inspection

Name of Establishment:	**Ulster Independent Clinic**
Establishment ID No:	**10636**
Date of Inspection:	**2 - 3 September 2014**
Inspector's Name:	**Winnie Maguire and Jo Browne**
Inspection No:	**17382**

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
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1.0 General Information

Name of establishment:	Ulster Independent Clinic
Address:	246 Stranmillis Road Belfast BT9 5JH
Telephone number:	028 9066 1212
Registered organisation/ registered provider:	Ulster Independent Clinic Diane Graham
Registered manager:	Diane Graham
Person in charge of the establishment at the time of inspection:	Diane Graham
Registration categories:	AH – Acute hospitals (with overnight beds), AH (DS) – Acute hospital (day surgery only), PD – Private doctors (others) PT (E) – Prescribed techniques or prescribed technology: establishments using endoscopy, PT (L) – Prescribed techniques or prescribed technology: establishments using Class 3b or Class 4 lasers
Registered beds:	70
Date and time of inspection:	2 September 2014 10.00 – 16.30 3 September 2014 10.00 – 16.15
Date and type of previous inspection:	3-4 December 2013 Announced Inspection
Names of inspectors:	Winnie Maguire Jo Browne

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect independent health care establishments. A minimum of one inspection per year is required.

This is a report of the announced inspection to assess the quality of services being provided. The report details the extent to which the regulations and DHSPPS Minimum Care Standards for Independent Healthcare Establishments, July 2014, measured during the inspection were met.

2.1 Purpose of the Inspection

The purpose of this inspection was to ensure that the service is compliant with relevant regulations, the minimum standards and to consider whether the service provided to patients was in accordance with their assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, procedures, practices and monitoring arrangements for the provision of an independent hospital, and to determine the provider's compliance with the following:

- The HPSS (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
- The Department of Health, Social Services and Public Safety's (DHSSPS) Minimum Care Standards for Independent Healthcare Establishments

Other published standards which guide best practice may also be referenced during the inspection process.

2.2 Methods/Process

Committed to a culture of learning, RQIA has developed an approach which uses self-assessment, a critical tool for learning. The self-assessment was forwarded to the provider prior to the inspection and was reviewed by the inspector prior to the inspection. The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.

Specific methods/processes used in this inspection include the following:

- Analysis of pre-inspection information and self-assessment
- Discussion with the registered provider/manager, Miss Diane Graham
- Examination of records
- Consultation with patients
- Tour of the premises
- Evaluation and feedback

Any other information received by RQIA about this registered provider and its service delivery has also been considered by the inspector in preparing for this inspection.

The completed self-assessment is appended to this report.

2.3 Consultation Process

During the course of the inspection, the inspector spoke with the following:

Patients	2
Patients' representatives	0
Staff	9
Other Professionals	0

2.4 Inspection Focus

The inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Minimum Care Standards for Independent Healthcare Establishments and to assess progress with the issues raised during and since the previous inspection.

- Standard 5 Patient and Client Partnerships
- Standard 6 Care Pathway
- Standard 7 Complaints
- Standard 9 Clinical Governance
- Standard 16 Management and Control of Operations
- Standard 31 Resuscitation
- Standard 32 Surgery

3.0 Profile of Service

Opened in 1979, the Ulster Independent Clinic is a private hospital situated on the Stranmillis Road in Belfast, three miles south of the city centre. The hospital is close to local amenities and public transport routes.

The hospital has 70 registered beds, 15 of which are primarily used by day patients. There are approximately 120 medical consultants who regularly admit patients to the hospital and another 150, including anaesthetists, radiologists and other specialists who regularly use the facility. In total around 400 medical practitioners have been granted practising privileges by the establishment, some of which do not use the facilities on a regular basis. The hospital is able to provide a comprehensive range of services, covering most specialities, except certain services which are only provided at regional level. There is on-site 24 hour medical care provided by full time Resident Medical Officers (RMOs).

The hospital has six theatres, three of which have laminar flow, two recovery wards, twelve consulting rooms in outpatients, two treatment rooms, a physiotherapy department, pharmacy, HDSU department, digital radiography, digital mammography, CT Scanning, ultrasound scanning and MRI.

The hospital is currently in the process of developing in-house pathology laboratory services and introducing the use of radioisotopes within their breast care service.

The hospital is accessible for patients and visitors with a disability.

Private car parking is available within the grounds of the hospital for patients and visitors to use.

Diane Graham is the manager of the establishment and has been registered manager since registration with RQIA on 11 April 2007.

The Ulster Independent Clinic is registered as an independent hospital with AH, AH(DS), PD, PT(E) and PT(L) categories of registration.

4.0 Summary of Inspection

An announced inspection was undertaken by Winnie Maguire and Jo Browne on 2 September 2014 from 10.00 to 16.30 and 3 September 2014 from 10.00 to 16.15. The inspection sought to establish the compliance being achieved with respect to 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, the DHSPPS Minimum Care Standards for Independent Healthcare Establishments and to assess the progress made to address the issues raised during the previous inspection.

There were three requirements and five recommendations made as a result of the previous annual announced inspection on 3 & 4 December 2013. One requirement had not been fully addressed and is restated within this report. The other requirements and recommendations had been fully addressed.

The inspection focused on the DHSPPS Minimum Care Standards for Independent Healthcare Establishments outlined in section 2.4 of this report.

Diane Graham was available during the inspection and for verbal feedback at the conclusion of the inspection.

During the course of the inspection the inspectors discussed operational issues, examined a selection of records and carried out a general inspection of the hospital.

There are robust systems in place to obtain the views of patients. The inspectors reviewed the completed patient questionnaires, along with the summary reports and found that patients were highly satisfied with the quality of care and treatment provided. Comments received from patients can be viewed in the main body of the report. Feedback from patients is used by the management of the hospital to improve patient services.

Patients are provided with a comprehensive information pack prior to their admission which outlines any pre-operative requirements, post-operative instructions and the arrangements for admission to the establishment.

The inspectors reviewed the care records of four patients undergoing surgery and found them to be well completed. The format and content of care records have been extensively revised and this process is nearing completion. There was a clear pathway of care recorded from the initial consultation, to informed consent, to admission, through pre-operative care, intra-operative care, post-operative care, review and discharge. Discussion with patients and staff confirmed that patients are fully involved in planning their care and treatment. The inspectors advised the hospital to evidence the involvement of patients in planning their care within the revised care records

A discharge letter summarising the patient's treatment and care is sent to the patient's general practitioner (GP) and any other relevant professionals who are involved in ongoing care and treatment, with the consent of the patient.

The hospital's complaints policy and procedure is in line with the DHSSPS guidance and legislation. The inspectors reviewed complaints management within the establishment and found that complaints were well documented, fully investigated and had outcomes recorded.

The registered manager is responsible for the day to day running of the establishment and ensuring compliance with the legislation and standards.

The hospital has systems in place to audit and monitor the quality of clinical care provided. The inspector reviewed audits and quality of clinical care indicators as outlined in the main body of the report.

The inspectors reviewed incident management and found that incidents were well documented, fully investigated and had outcomes recorded. Audits of incidents were undertaken as part of the hospital's clinical governance systems. Arrangements were in place to disseminate learning outcomes throughout the organisation. The inspectors noted that not all notifiable incidents had been reported to RQIA in line with the legislation and RQIA guidance. Further explanation was provided on this matter by the inspectors and a requirement is restated for a second time.

The registered manager outlined arrangements in place for the participation of the hospital in an external research project. The arrangements were noted to be in line with best practice. The hospital does not have a written policy and procedure on research and a recommendation was made to devise one.

There is a defined management structure within the hospital and clear lines of accountability.

The inspectors reviewed the policy and procedures in relation to the absence of the registered manager and whistle blowing. They were found to be in line with legislation and best practice.

The registered manager undertakes ongoing training to ensure that they are up to date in all areas relating to the provision of services.

A Statement of Purpose and Patient Guide were in place which reflected legislative and best practice guidance.

The inspectors confirmed that appropriate meals are provided in line with the assessed needs of the patients.

The inspectors reviewed the insurance arrangements for the hospital and found that current insurance policies were in place.

There is a written resuscitation policy in place. Staff had received basic life support training and updates. There is always at least one staff member with advanced life support training on duty at all times.

Staffs involved in the provision of paediatric care have paediatric life support training and updates. When children are admitted for treatment there is at least one staff member on duty trained in paediatric advanced life support.

There is a range of resuscitation equipment in place which is checked and restocked to ensure all equipment remains in working order and is suitable for use at all times. It was noted that some additional equipment was included in the resuscitation trolley and the inspectors advised adding this equipment to the checklist or removing it.

The establishment has a range of policies and procedures for surgical procedures which are in accordance with good practice guidelines and national standards.

The scheduling of patients for surgical procedures is co-ordinated by the theatre manager, the surgeon and the booking office staff. The theatre lists take into account the individual requirements of the patient, the type of procedure to be undertaken, equipment required, associated risks and the level of sedation used.

The inspectors reviewed the theatre facilities and met with staff and discussed the management of intraoperative care and immediate post op care. Staff displayed a good understanding of the topics discussed.

The inspectors met with the theatre manager and deputy theatre manager to discuss arrangements in theatre and they also discussed the recommendations made in relation to the theatre review undertaken in December 2013 by a review team from RQIA and confirmed that appropriate action had been taken to address the issues identified.

Overall, on the day of inspection, the hospital was found to be providing a quality, safe and effective service to patients.

The certificates of registration were clearly displayed in the entrance hallway.

There was one requirement and one recommendation made as result of this inspection. These are discussed fully in the main body of the report and in the appended Quality Improvement Plan.

The inspectors would like to thank Diane Graham, patients and staff of the Ulster Independent Clinic for their hospitality and contribution to the inspection process.

5.0 Follow Up on Previous Issues

No.	Regulation Ref.	Requirements	Action taken as confirmed during this inspection	Number of times stated	Inspector's validation of compliance
1	8 (1)	The registered provider/manager must ensure that a Patient Guide is developed or the hospital information booklets are amended to include all of the information required by legislation.	The inspectors reviewed the new patient guide. Some minor amendments were made during the inspection which ensured that the document contained all of the information required by legislation.	One	Compliant
2	28 (1)	The registered provider/manager must ensure that all notifiable incidents are reported to RQIA in line with the legislation and RQIA guidance.	A review of incidents records indicated that a small number of incidents had not been reported to RQIA in line with the legislation. This requirement is restated for the second time within this report.	One	Not compliant
3	19 (1) (b) (3)	The registered manager must ensure that all medical practitioners have up to date information in their personnel files as outlined in the main body of the report.	Review of a random selection of medical practitioner files confirmed that all information required by legislation was retained.	Two	Compliant

No.	Minimum Standard Ref.	Recommendations	Action taken as confirmed during this inspection	Number of times stated	Inspector's validation of compliance
1	C4.2	The registered provider/manager should ensure that the summary report of patient feedback is made available to patients and other interested parties to read.	The summary report of patient feedback is made available within the hospital and the organisation's website for patients and other interested parties to read.	One	Compliant
2	C17.3	The registered provider/manager should ensure that all correction fluid is not used on records and any alterations are dated, timed, signed and made in such a way that the original entry can still be read.	Review of records confirmed that correction fluid was not being used and any alterations were made in line with best practice.	One	Compliant
3	C11.2	The registered provider/manager should ensure that the incident policy and procedure is updated in line the notifiable events guidance issued by RQIA.	Review of the incident policy and procedure confirmed that it had been updated in line with the notifiable events guidance issued by RQIA.	One	Compliant
4	16	The registered manager should develop a whistleblowing policy as outlined in the main body of the report.	The hospital had established a comprehensive whistleblowing policy and procedure.	One	Compliant
5	16	The registered manager should action the cracked and broken bath panel as outlined in the main body of the report.	The registered manager confirmed that the broken bath panel had been repaired.	One	Compliant

6.0 Inspection Findings

STANDARD 5	
Patient and Client Partnerships:	**The views of patients and clients, carers and family members are obtained and acted on in the evaluation of treatment, information and care**

The Ulster Independent Clinic obtains the views of patients on a formal and informal basis as an integral part of the service they deliver.

In-patient, day patient, parents and children are offered the opportunity to complete a satisfaction questionnaire within the hospital. A child friendly questionnaire is available for children to complete using pictures.

The inspectors reviewed a random selection of forty completed questionnaires and found that patients, parents and children were highly satisfied with the quality of treatment, information and care received. Comments received on the feedback questionnaires included:

- "We were all extremely well looked after by everyone"
- "Excellent ,competent and very caring staff"
- "The standard of care and attention was exceptional"
- "Nerves were put at ease very quickly and felt really reassured "
- "The care from the breast care nurses was brilliant"
- "All three breast care nurses were compassionate and professional"
- "Medical staff in the recovery were most attentive and did an excellent job"
- "Treatment of an exceptionally high standard "
- "Catering staff were especially helpful and friendly"
- "Food was excellent"

The results of the feedback questionnaires are reviewed by the senior management team within the hospital and an action plan is developed and implemented if any issues are identified. Feedback from patients, parents and children is included in the overall clinical governance strategy and report.

The information received from the patient feedback questionnaires is collated into an annual summary report which is made available to patients and other interested parties to read in within the hospital and on the establishment's website.

The inspectors met with two patients during the course of the inspection who felt that their views and opinions were valued by the hospital.

Evidenced by:

Review of patient satisfaction surveys
Review of summary report of patient satisfaction surveys
Summary report made available to patients and other interested parties
Discussion with patients and staff

STANDARD 6	
Care Pathway:	**Patients and clients have a planned programme of care from the time of referral to a service through to discharge and continuity of care is maintained.**

Patients are provided with a comprehensive information pack prior to their admission which outlines any pre-operative requirements and the arrangements for their stay in the hospital.

The establishment has a wide range of information leaflets available regarding the types of procedures available. Ms Graham confirmed that information can be provided in an alternative language or format if required.

The inspectors spoke with two patients who both confirmed that they had received comprehensive information prior to their admission and from the multi-disciplinary team following their admission.

A range of clinical assessments are undertaken by the different members of the health care team prior to surgery and the outcomes are recorded in the individual patient care records. Systems are in place to refer patients to specialist services to meet the assessed needs of the patients, e.g. physiotherapy and occupational therapy.

The hospital is currently reviewing the format of their care records and care plans. The inspectors reviewed the care records of four patients and found that the care records contained comprehensive information relating to pre-operative, intra-operative and post-operative care which clearly outlined the patient pathway and included the following:

- Patient personal information
- Holistic assessments
- Pre-operative care plans
- Pre-operative checks
- Signed consent forms
- Surgical safety checklist (WHO)
- Operation notes
- Anaesthetic notes
- Medical notes
- Intra-operative care plans
- Recovery care plans
- Post-operative care plans
- Multidisciplinary notes
- Daily statement of the patient's condition
- Discharge plan

Discussion with patients confirmed that patients are fully involved in planning their care and treatment. The inspectors advised the hospital to evidence the involvement of patients in planning their care within the revised care records.

Patients who spoke with the inspectors confirmed that they had received written information regarding their treatment and had the opportunity to meet with their surgeon prior to going to theatre and discuss the nature of the surgery, the risks, complications and expected outcomes before signing the consent form. The consent forms reviewed by the inspectors were signed by the consultant surgeon and the patient.

Comments received from patients regarding their stay in the hospital included:

- "The proficiency, care, courtesy and kindness shown by everyone from the receptionist onwards"
- "The food is superb, better than you would expect to get anywhere"
- "The tissue viability nurse is an absolute legend"
- "The cleanliness is excellent"
- "The care has been marvellous"
- "Everyone has been good at their jobs"
- "I was kept informed at every step of the way "
- "The food was excellent anything I wanted I could have got"
- "They keep the place spotless"
- "Noticed staff very careful about washing their hands"

Patients and staff confirmed that the results of investigations and treatment provided are explained. Future treatment options are discussed and patients are involved in the decision making process.

The establishment has a dedicated discharge planning sister who ensures continuity of care for patients following discharge. The planned discharge programme in place provides the patient with information on the future management of their condition, supply of medication, liaison with community services, follow up advice and support including what to do in the event of a complication or problem.

Arrangements are in place to ensure that children and young people are discharged from the hospital as soon as their condition allows and when ongoing care can be provided at home. Most children attending the hospital are treated as day cases.

A discharge letter summarising the patient's treatment and care is sent to the patient's general practitioner (GP) and any other relevant professionals who are involved in ongoing care and treatment.

Evidenced by:

Review of patient care records
Discussion with patients
Discussion with staff
Discharge plan and letter to GP or other relevant professionals

STANDARD 7	
Complaints:	**All complaints are taken seriously and dealt with appropriately and promptly.**

The hospital operates a complaints policy and procedure in accordance with the DHSSPS guidance on complaints handling in regulated establishments and agencies and the legislation. Ms Graham demonstrated a good understanding of complaints management.

All patients are provided with a copy of the complaints procedure, a summary of which is contained within the Patient Guide. A copy of the complaints procedure is also displayed on notice boards throughout the hospital. Ms Graham confirmed that the complaints procedure could be made available in alternative formats and languages if required.

The inspectors reviewed the complaints register and complaints records. All complaints were well documented, fully investigated and had outcomes recorded in line with the complaints procedure and legislation.

All complaints are graded by Ms Graham and an audit of complaints is undertaken monthly and as part of the establishment's quality assurance mechanisms. The audit information is used to identify trends and enhance services provided as part of the hospital's overall clinical governance strategy. No major trends or themes were identified within the records reviewed during the inspection.

Patients who met with the inspectors confirmed that they had been made aware of how to raise a complaint; however they had no concerns regarding the quality of care provided and were very complimentary regarding the hospital and staff.

Evidenced by:

Review of complaints procedure
Complaint procedure made available to patients and other interested parties
Discussion with patients
Discussion with staff
Review of complaints records
Review of the audit of complaints

STANDARD 9	
Clinical Governance:	**Patients and clients are provided with safe and effective treatment and care based on best practice guidance, demonstrated by procedures for recording and audit.**

Ms Graham ensures the establishment delivers a safe and effective service in line with the legislation, other professional guidance and minimum standards.

Discussion with Ms Graham, staff and review of training records confirmed that systems are in place to ensure that staff receive appropriate training when new procedures are introduced.

Ms Graham informed the inspectors that all policies and procedures will be uploaded and made available on the hospital's intranet.

The establishment has robust systems in place to audit the quality of service provided and a planned audit programme is in place. The inspectors reviewed the following audits as part of the inspection process:

- Clinical quality indicators
- Patient feedback
- Wound infection
- Health record management
- Completion of surgical safety checklist
- Pre-operative visiting of patients by theatre staff
- Accident/incident /near misses
- Annual physiotherapy audit
- Annual radiology department audit
- Annual outpatients audit
- Paediatric admissions
- Patient transfer to acute care settings
- Infection prevention and control
- Sharps injuries
- Adverse drug reactions

Systems are in place to ensure that the quality of services provided by the hospital is evaluated on an ongoing basis and discussed with relevant stakeholders.

Ms Graham is involved in the day to day running of the establishment and systems are in place to directly discuss any ongoing issues with the board of directors who meet ten times per annum. There also are numerous meetings which occur throughout the year and support the clinical governance structures within the hospital as follows:

- Board sub-committees – as required
- Operational management group – monthly
- Senior clinical staff committee – ten times per annum

- Medical staff committee – bi-monthly
- Sisters meeting – annually
- Risk management committee – quarterly
- Health and safety committee – quarterly
- Paediatric committee – annually
- Clinical governance/medical audit group – quarterly
- Health records management group – annually
- Radiology users group – annually
- Theatre users group – bi-monthly
- Pharmacy users group – three times per annum
- Chemo users group – twice per annum
- Departmental meetings
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There are clear arrangements for monitoring the quality of clinical care that include the following indicators:

- Unplanned returns to theatre
- Peri-operative deaths
- Unplanned re-admissions to hospital
- Unplanned transfers to other hospitals
- Adverse clinical incidents
- Post-operative infection rates for the hospital

Following the previous inspection the establishment reviewed and updated their incident policy and procedure to include reporting arrangements to RQIA.

The inspector reviewed incident management and found that incidents were well documented, fully investigated and had outcomes recorded. Audits of incidents are undertaken and learning outcomes are identified and disseminated throughout the organisation.

Robust systems were in place to report incidents involving equipment to the Northern Ireland Adverse Incident Centre (NIAIC). Where staff members were involved in incidents, arrangements were in place to provide additional training, support and ongoing competency assessments.

A small number of incidents were identified that should have been reported to RQIA and a restated requirement is made in this regard. The inspectors discussed the type of incidents that require to be reported under the legislation and again suggested that Ms Graham contacts RQIA for advice and support in relation to this matter.

Ms Graham confirmed that no research is currently being directly undertaken by the hospital. However the hospital does participate in providing data for external research projects. Ms Graham assured the inspectors that approval had been obtained from the appropriate Research Ethics Committee (REC) and the proposal was discussed and agreed through the governance and medical audit committee.

It is recommended that the hospital develops a policy and procedure for participating in external research projects.

Evidenced by:

Review of policies and procedures
Review of training records/competency records
Discussion with registered provider/manager
Review of monitoring reports
Review of audits
Review of incident management
Review of research arrangements

STANDARD 16	
Management and Control of Operations:	**Management systems and arrangements are in place that ensure the delivery of quality treatment and care.**

There is a defined organisational and management structure that identifies the lines of accountability, specific roles and details responsibilities for all areas of the service.

The establishment has a policy and procedure in place to ensure that RQIA is notified if the registered manager is absence for more than 28 days. The policy includes the interim management arrangements for the establishment.

Review of the training records and discussion with Ms Graham confirmed that she undertakes training relevant to her role and responsibilities within the organisation.

The inspectors reviewed the establishment's Statement of Purpose and found it to be in line with the legislation. Some minor amendments were made to the Patient Guide during the inspection in relation to obtaining the summary report of the patient satisfaction survey and a copy of the most recent RQIA inspection report; the revised document contained all of the information required by legislation.

The inspectors confirmed that appropriate meals are provided in line with the assessed needs of the patients. A wide variety of menus were available and included menus for:

- Day procedure patients
- Children's day procedures
- Same day surgery
- In-patients
- Children's in-patient
- Special diets
- Light diets
- Admissions

Patients were offered an excellent choice of meals and could select the required portion size according to their appetite. The menus also highlighted healthy and vegetarian options.

Patients who met with the inspectors spoke extremely positively regarding the quality and quantity of food provided.

Ms Graham confirmed that no agency staff are used within the hospital as the hospital have recruited their own bank staff.

There was a comprehensive written policy on "Whistle Blowing" and written procedures that identify to whom staff report concerns about poor practice and the support mechanisms available to those staff.

The inspectors discussed the insurance arrangements within the establishment and confirmed current insurance policies were in place. The certificates of registration and insurance were clearly displayed in the foyer of the premises.

Evidenced by:

Review of policies and procedures
Review of training records
Review of Patient Guide
Review of Statement of Purpose
Review of arrangements for meals
Review of insurance arrangements

STANDARD 31	
Resuscitation:	**Resuscitation equipment is readily accessible and resuscitation is carried out by trained competent staff and in line with the Statement of Purpose.**

There is a written resuscitation policy in place which was found to be in line with the Resuscitation Council (UK) guidelines.

Staff had received basic life support training and updates. There is always at least one staff member with advanced life support training on duty at all times. Ms Graham informed the inspectors that all sisters who are left in charge of the hospital recently received intermediate life support training.

Staff involved in the provision of paediatric care have paediatric life support training and updates. When children are admitted for treatment there is at least one staff member on duty trained in paediatric advanced life support.

The inspectors discussed arrangements regarding patients with a "Do Not Resuscitate" (DNR) order in place. Ms Graham confirmed that patients who would have a DNR order in place would not meet the normal admission criteria for elective surgery within the hospital.

Occasionally a patient with a DNR order in place may be admitted for other procedures and following discussion appropriate arrangements were in place to document and review the DNR order under these circumstances.

There is a range of resuscitation equipment in place in various departments throughout the hospital. The inspectors reviewed the contents of the resuscitation trolley on Level 1 and found that it contained all of the required equipment and medication. It was noted that some additional equipment was included in the trolley and the inspectors advised adding this to the check list or removing it.

Equipment for resuscitating patients includes:

- A charged defibrillator and ECG monitor
- Portable oxygen with appropriate valves, mask, metering and delivery system
- First line resuscitation medication
- Equipment for maintaining and securing the airway of a patient
- Equipment to insert and maintain intravenous infusions
- Latex free alternative equipment
- Paediatric intubation tray where children are treated
- Paediatric first line resuscitation equipment and medication

Resuscitation equipment is checked twice daily and restocked to ensure all equipment remains in working order and suitable for use at all times.

A record of all equipment and drugs is attached to the resuscitation trolley and a written record is retained of the equipment checks and weekly medication checks.

Resuscitation equipment is cleaned and decontaminated following use.

Evidenced by:

Review of resuscitation policy and procedure
Review of records of resuscitation equipment and checks
Review of resuscitation equipment
Review of resuscitation training
Review of paediatric resuscitation procedures, equipment and medication

STANDARD 32	
Surgery:	**There are arrangements in place to support the provision of safe and effective surgical practices.**

The establishment has a wide range of comprehensive policies and procedures in place to ensure that safe and effective care is provided to patients which are in accordance with good practice guidelines and national standards.

Within the hospital there is a defined staff structure for surgical services which clearly outlines areas of accountability and individual roles and responsibilities.

The scheduling of patients for surgical procedures is co-ordinated by the theatre manager, the surgeon and booking office staff. The theatre lists take into account the individual requirements of the patient, the type of procedure to be performed, availability of equipment, staffing levels required, associated risks and level of sedation used.

The inspectors undertook a review of the general theatre environment, stores, linen cupboard, offices, and recovery wards in both main theatres and block B. The inspectors were able to review one theatre in Block B as surgery was ongoing in the other theatres at the time of inspection. The environment was found to be clean, tidy and free from clutter. No issues were identified as requiring to be addressed.

The inspectors met with the theatre manager and deputy theatre manager to discuss arrangements in theatre. The inspectors also discussed the recommendations made in relation to the theatre review undertaken in December 2013 by a review team from RQIA and confirmed that appropriate action had been taken to address the issues identified. The following issues were discussed:

- Management of sharps containers in line with best practice
- Introduction of new controlled drug registers
- Theatre checklists for morning and evening
- Theatre checklist for emergency theatre
- Surgical Site Infection surveillance
- Assessment of risk of Venous Thromboembolism (VTE)
- Purchase of new medical devices and training on their use
- Monitoring of patient temperatures in theatre and management of malignant hypothermia
- Deep cleaning schedules for theatres
- Introduction of new linen cupboard
- Maintenance issues identified in review were all addressed
- Provision of new footwear for staff
- Storage of cleaning materials in line with Control of Substances Hazardous to Health (COSHH)
- Provision of additional alcohol based hand gels in sluices and cleaners store
- Additional training including scenario based training for emergency situations

The inspectors discussed staffing levels and the theatres were found to have adequate staffing levels to meet the individual needs of the patients undergoing surgery.

There is an identified senior member of nursing staff, with theatre experience, in charge of the operating theatre at all times and a permanent record of the team leader is retained.

The inspectors reviewed the register which is maintained for all surgical procedures undertaken in the hospital and found it contained all of the information required by legislation.

On discussion staff confirmed a five point surgical checklist based on the World Health Organisation (WHO) model is used within the hospital. The inspectors reviewed completed surgical checklists within the patients' care records. Completion of the surgical checklists is audited by the theatre manager and review of the audits confirmed that a high level of compliance is achieved.

Prior to surgery, the inspectors confirmed, that patients receive verbal and written pre-operative information on:

- Fasting
- Taking of existing medication
- Arrangements for escort to and from theatre

Review of the patient care records and discussion with staff and patients confirmed that the anaesthetist who gives the anaesthetic visits the patient prior to surgery to:

- assess their general medical fitness
- review their medication
- explain the type of anaesthetic to be used
- discuss options for post-operative pain relief

The inspectors were informed the anaesthetist is present throughout the operation and is present onsite until the patient has recovered from the immediate effects of the anaesthetic.

Discussion with staff confirmed that patients are observed during surgery and in the recovery room on a one to one basis by staff trained in anaesthetics and resuscitation.

The inspectors discussed intra-operative fluid management and reviewed the procedure and documents used for the management of glycine during Transurethral Resection of the Prostate (TURP) and Transcervical Resection of Endometrium (TCRE) procedures. While the documentation reviewed provided a comprehensive overview of fluids management during the operation advice was provided regarding the format of the documentation to ensure that it was consistent with the procedure. The theatre manager informed the inspectors that the documents were still in draft format and work remained ongoing.

The theatre manager informed the inspectors that an identified member of staff is responsible for the recording of all intra-operative fluid within theatre as outlined in the policy and procedure. The hospital is in the process of procuring new equipment which will assist in the accurate measurement of fluid balance.

The hospital has discharge criteria in place from recovery to the ward area and to home for day case patients.

Patients are provided with written post-operative instructions relevant to their individual procedure which includes:

- Pain relief
- Bleeding
- Care of the post-operative site
- The potential effects of anaesthesia

Equipment, installations and facilities are in place to provide the services outlined in the hospital's Statement of Purpose. There are systems in place to ensure that theatre equipment is maintained and decontaminated in line with the manufacturers' guidelines.

The hospital has introduced a new medical devices management system that will be uploaded on to the intranet and will inform relevant senior staff when equipment is due to be serviced.

Evidenced by:

Review of theatre policies and procedures
Review of surgical register of operations
Discussion with theatre manager
Discussion with deputy theatre manager
Discussion with staff
Discussion with patients
Review of facilities
Review of service records for equipment

7.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Diane Graham as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider / manager is required to record comments on the Quality Improvement Plan.

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

Enquiries relating to this report should be addressed to:

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

Quality Improvement Plan

Announced Inspection

Ulster Independent Clinic

2 - 3 September 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Diane Graham during the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

STATUTORY REQUIREMENT

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Independent Health Care Regulations (Northern Ireland) 2005 and The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011.

NO.	REGULATION REFERENCE	REQUIREMENT	NUMBER OF TIMES STATED	DETAILS OF ACTION TAKEN BY REGISTERED PERSON(S)	TIMESCALE
1	28 (1)	The registered provider/manager must ensure that all notifiable incidents are reported to RQIA in line with the legislation and RQIA guidance. **Ref: Standard 9**	Two	The process has been reviewed and the requirement actioned.	Immediately and ongoing

RECOMMENDATION

This recommendation is based on the DHSPPS Minimum Care Standards for Independent Healthcare Establishments, research or recognised sources. This promotes current good practice and if adopted by the registered person/manager may enhance service, quality and delivery.

NO.	MINIMUM STANDARD REFERENCE	RECOMMENDATION	NUMBER OF TIMES STATED	DETAILS OF ACTION TAKEN BY REGISTERED PERSON(S)	TIMESCALE
1	9.10	The registered provider/manager should develop a policy and procedure for the hospital participating in external research projects. **Ref: Standard 9**	One	This has been actioned	Within three months

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person and return to independent.healthcare@rqia.org.uk

Name of Registered Manager Completing QIP	Diane Graham
Name of Responsible Person / Identified Responsible Person Approving QIP	Diane Graham

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	x	Winnie Maguire	3 /11/14
Further information requested from provider			

The Regulation and Quality Improvement Authority

Pre-Inspection Self-Assessment
Independent Hospital

Name of Establishment:	**Ulster Independent Clinic**
Establishment ID No:	**10636**
Date of Inspection:	**2 September 2014**
Inspector's Name:	**Winnie Maguire**
Inspection No:	**17382**

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect independent health care establishments. A minimum of one inspection per year is required.

The aim of inspection is to examine the policies, procedures, practices and monitoring arrangements for the provision of an independent hospital, and to determine the provider's compliance with the following:

- The HPSS (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
- The Department of Health, Social Services and Public Safety's (DHSSPS) draft Independent Health Care Minimum Standards for Hospitals and Clinics

Other published standards which guide best practice may also be referenced during the inspection process.

2.0 Self-Assessment

Committed to a culture of learning, RQIA has developed an approach which uses self-assessment.

Where asked in the self-assessment you are required to indicate a yes or no response. You are also asked to provide a brief narrative in the "text box" where applicable.

Following completion of the self-assessment, please return to RQIA by the date specified.

The self-assessment will be appended to the report and made available to the public. No amendments will be made by RQIA to your self-assessment response.

3.0 Self-Assessment Tool

Management of Operations

	YES	NO
Has any structural change been made to the premises since the previous inspection?		
Have any changes been made to the management structure of the hospital since the previous inspection?		✓
Yes, please comment WORK HAS COMMENCED TO RE-CONFIGURE INTERNAL STRUCTURES TO CREATE A LABORATORY		

Policies and Procedures

	YES	NO
Does the hospital have a policy and procedure manual in place which is reviewed at least every 3 years or as changes occur?	✓	
Are the policies and procedures for all operational areas in line with legislation and best practice guidelines?	✓	
Do all policies and procedures contain the date of issue, date of review and version control?	✓	
Are all policies and procedures ratified by the registered person?		✓
No, please comment DEPARTMENTAL SPECIFIC POLICIES ARE RATIFIED BY THE HEAD OF THAT DEPARTMENT OR SERVICE.		

Records Management

	YES	NO
Does the hospital have a policy and procedure in place for the creation, storage, transfer, retention and disposal of and access to records in line with the legislation?	✓	
Are care records maintained for each individual patient?	✓	
Do the care records reflect the patient pathway from referral to discharge?	✓	
Are arrangements in place to securely store patient care records?	✓	
No, please comment		

Patient Partnerships

	YES	NO
Does the hospital have systems in place to obtain the views of patients regarding the quality of treatment, care and information provided?	✓	
Does the hospital make available a summary report of patient feedback to patients and other interested parties?	✓	
No, please comment		

Resuscitation

	YES	NO
Does the hospital have a resuscitation policy and procedure in place which is in line with the Resuscitation Council (UK) guidance?	✓	
Is resuscitation equipment readily accessible in all clinical areas?	✓	
Are arrangements in place to ensure resuscitation equipment is checked regularly and restocked to ensure all equipment remains in working order and suitable for use at all times?	✓	
Is there at least one person with advance life support training on duty at all times?	✓	
Where children are admitted for treatment, is there at least one person with paediatric advanced life support training on duty at all times?	✓	
No, please comment		

Safeguarding

	YES	NO
Does the hospital have a protection of vulnerable adults policy and procedure in place which is in line with the legislation and regional guidance?	✓	
Does the hospital have a safeguarding children policy and procedure in place which is in line with the legislation and regional guidance?	✓	
Does the hospital have a whistle-blowing policy and procedure in place?	✓	
No, please comment		

Complaints

	YES	NO
Does the hospital have a complaints policy and procedure in place which is in line with the legislation and the DHSSPS guidance on complaints handling in regulated establishments and agencies April 2009?	✓	
Are all complaints documented, fully investigated and have outcomes recorded in line with the legislation and the hospital's complaints policy and procedure?	✓	
No, please comment		

Incidents

	YES	NO
Does the hospital have an incident policy and procedure in place which complies with the legislation and RQIA guidance?	✓	
Are all incidents reported, documented, fully investigated and have outcomes recorded in line the legislation, RQIA guidance and the hospital's policy and procedure?	✓	
No, please comment		

Infection Prevention and Control

	YES	NO
Does the hospital have an infection prevention and control policy and procedure in place?	✓	
Are appropriate arrangements in place to decontaminate equipment between patients?	✓	
Does the hospital use single use surgical instruments?	✓	
Does the hospital have appropriate service level agreements in place for the sterilisation of surgical equipment? *	✓	
No, please comment * THIS IS UNDERTAKEN ON SITE IN THE HOSU DEPARTMENT		

Recruitment of staff

	YES	NO
Does the hospital have a recruitment and selection policy and procedure in place?	✓	
Is all information outlined in Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005 retained and available for inspection?	✓	
Have all staff had an enhanced AccessNI disclosure undertaken, prior to commencing employment?	✓	
No, please comment		

Staffing

	YES	NO
Is there appropriate numbers of suitably qualified, skilled and experienced staff on duty to meet the assessed needs of the patients and the operational requirements of the hospital?	✓	
No, please comment		

Mandatory Training

	YES	NO
Are arrangements in place for all new staff to participate in an induction programme relevant to their roles and responsibilities?	✓	
Are arrangements in place for staff to access continuing professional development opportunities in line with the requirements of their professional bodies?	✓	
Are training records available which confirm that the following mandatory training has been undertaken:		
	YES	**NO**
Moving and Handling – annually	✓	
Protection of vulnerable adults – every 3 years	✓	
Safeguarding children (where services are provided to children) – every 3 years	✓	
Infection prevention and control training – annually	✓	

Fire safety – annually	✓	
Basic adult life support - annually	✓	
Basic paediatric life support (where services are provided to children) - annually	✓	
If No, please comment		

Appraisal

	YES	NO
Does the hospital have an appraisal policy and procedure in place?	✓	
Are systems in place to provide recorded annual appraisals for staff?	✓	
No, please comment		

Medical Practitioners, Nurses, Social Workers & Allied Health Professionals

	YES	NO
Are systems in place to ensure medical, nursing staff, social workers and allied health professionals have a current registration with their relevant professional bodies?	✓	
Are policies and procedures in place to grant, review and withdraw practising privilege agreements for medical practitioners?	✓	
Are practising privileges agreements in place for all medical practitioners? (where applicable)	✓	
Are systems in place to ensure that medical practitioners have up to date professional indemnity insurance?	✓	
Are systems in place to ensure that medical practitioners have an annual appraisal undertaken with a trained medical appraiser?	✓	
Are arrangements in place to ensure medical practitioners have a responsible officer?	✓	
No, please comment		

Surgical Services

	YES	NO
Are there suitable arrangements in place to provide appropriate pre-operative, peri-operative and post-operative care for patients?	✓	
Is an holistic assessment of patients care needs, using validated tools, carried out?	✓	
Are patient centred care plans developed and implemented for each patient and reviewed as changes occur?	✓	
Are contemporaneous medical records retained for each individual patient?	✓	
Does the hospital have a theatre manual in place?	✓	
Is there a register of operations retained that contains all of the information outlined in the legislation?	✓	
Does the hospital use the World Health Organisation (WHO) surgical checklist for each operation undertaken?	✓	
Does the hospital have systems in place for surgical pause?	✓	
Does the hospital provide endoscopy services?	✓	
Are there suitable arrangements in place for the provision of endoscopy services in line with best practice guidance? (where applicable)	✓	
Are systems in place to provide discharge information to patient's general practitioners and others involved in the patient's ongoing care?	✓	
Are arrangements in place for the collection, labelling, storage, preservation, transport and administration of specimens?	✓	
No, please comment		

4.0 Declaration

To be signed by the registered provider or registered manager for the establishment.

I hereby confirm that the information provided above is, to the best of my knowledge, accurately completed.

Name	Signature	Designation	Date
DIANE GRAHAM		MATRON/CHIEF EXECUTIVE	15/8/14