The Regulation and Quality Improvement Authority

Unannounced Inspection Report
4 November 2019

Ulster Independent Clinic

Type of Service: Independent Hospital – Acute Hospital
Address: 245 Stranmillis Road, Belfast BT9 EJH
Tel No: 028 9066 1212
Inspectors: Sheelagh O'Connor and Carmel McKeegan

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of the hospital

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

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

3.0 Service details

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

Laser equipment (located in theatre five)

Manufacturer: Cook Medical

Model: H30 Holmium laser system

Serial Number: LHT65630416

Laser Class: 4

Laser protection advisor (LPA): Philip Loan

Laser protection supervisor (LPS): Sister Katherine Stanley

Clinical authorised users: Six named Consultant Urologists

Types of treatment provided: Laser fragmentation of ureteric stones

4.0 Inspection summary

We undertook an unannounced inspection to the Ulster Independent Clinic (UIC) on 4 November 2019.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Independent Health Care Regulations (Northern Ireland) 2005, The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health (DOH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

The focus of the inspection was to assess progress made by UIC to address specific areas of concerns identified as a result of our unannounced inspection of UIC on 22, 23 and 24 January 2019 and further discussed as part of a serious concerns meeting held in RQIA on 17 July 2019. These concerns related to UIC's review of its overarching governing systems; medical governance, in particular the management and oversight of practising privileges and non-consultant grade doctors operating as surgical assistants in UIC; and risk assessment and prevention of venous thromboembolism (VTE) policy and procedures.

We examined the following areas during the inspection:

- progress made in relation to UIC's review of its overarching governing systems
- arrangements for medical governance/practicing privileges;
- arrangements for non-consultant grade doctors operating as surgical assistants; and
- policy and procedures relating to risk assessment and prevention of VTE.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement stated for the second time	2	0

We were provided with an update regarding the integrated governance review of UIC and the appointment of a new full time staff member dedicated to strengthen the governance systems across the hospital.

We determined that the hospital does not have an appropriate system either established or in preparation for granting and maintaining practising privileges for medical practitioners working in the hospital. We also found that non-consultant grade doctor's staff continue to operate as surgical assistants within the hospital without appropriate governance or monitoring systems in place. RQIA had previously brought our concerns regarding these aspects of medical governance to the UIC's attention during our inspection from 22 - 24 January 2019, in the draft quality improvement plan (QIP) issued in May 2019 and as part of our serious concerns meeting held in RQIA with UIC on 17 July 2019.

We found that the hospital had not made sufficient and necessary improvements to address our concerns in relation to oversight and management of practising privileges for medical practitioners, information relating to doctors working in wholly private practice and the use of non-consultant grade doctors as surgical assistants in the hospital.

We found that a revised VTE policy and procedure had been developed in keeping with current best practice guidance and progress had been made with respect to the implementation of this policy and procedure. We identified that progress had been made with respect to the implementation of the revised VTE policy and procedure however we highlighted at feedback the need to immediately commence a robust audit of the implementation of the revised VTE policy and associated procedures.

As a result of the inspection findings we invited Ms Graham, Chief Executive/Matron (Responsible Individual) and Chairman of the Board of Directors to attend an Intention to Serve Failure to Comply Notice meeting in RQIA on 13 December 2019 to discuss our inspection findings. During this meeting UIC provided RIQA with an updated schedule of information required by legislation in relation to medical practitioners with practising privileges. However, there was no agreed standard operating procedure to define the process for application, granting, maintenance and withdrawal of practising privileges in place for the hospital. We remained concerned and were not assured that the hospital's Responsible Individual or Board of Directors had appropriate arrangements for medical governance in place and robust oversight and management of practising privileges.

We determined to serve one Failure to Comply Notice (Ref: 000086) in respect of non-compliance with Regulation 19 of The Independent Health Care Regulations (Northern Ireland) 2005; compliance to be achieved by 23 February 2020.

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

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

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

4.2 Action/enforcement taken following the previous inspection on 22, 23 and 24 January 2019

During our inspection to UIC from 22 - 24 January 2019 we identified a number of areas of significant concern, these included arrangements relating to overarching governing systems, medical governance and specifically the arrangements relating to oversight and management of practicing privileges and for non-consultant grade doctors operating as surgical assistants.
We also found that the hospital's policy and procedures relating to risk assessment and prevention of venous thromboembolism (VTE) were not in line with current best practice guidance.

These concerns were highlighted to Ms Graham, Chief Executive/Matron during a feedback session held on 24 January 2019 at the conclusion of our inspection.

As no members of the UIC's Senior Management Team attended this feedback session we requested a second feedback meeting. A second feedback session took place on 19 February 2019 at which UIC were represented by Ms Graham, the Chair of the Clinical Governance and Medical Audit Sub-Committee(CGMASC), the Chairman of the Board of Directors, a medical member of the Board of Directors, the Responsible Officer for UIC and the Chair of the Medical Staff Committee. Our concerns were also outlined in the draft QIP issued to UIC on 22 May 2019 and at a Serious Concerns meeting held with senior management from UIC on 17 July 2019.

On 9 August 2019 RQIA wrote to UIC outlining the actions required to provide assurance that the concerns identified were being appropriately addressed. We required submission of a completed action plan by 2 September 2019, with a monthly update on progress thereafter. We advised that a follow-up unannounced inspection of UIC would be undertaken to ensure improvements had been made.

We received monthly updates from UIC in September, October and November 2019. Following our analysis of the information submitted we were concerned that insufficient progress had been made in respect of the oversight and management of medical governance/practising privileges and arrangements for non-consultant grade doctors operating as surgical assistants in UIC. As a result of our concerns we carried out an unannounced focused inspection to UIC on 4 November 2019.

5.0 How we inspect

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

- notifiable events since the previous inspection;
- registration status of the establishment;
- written and verbal communication received since the previous inspection;
- the previous inspection report;
- QIP returned following the previous inspection; and
- submitted action plans from UIC for September, October and November 2019.

During our inspection we met with and spoke with the following staff: Theatre Manager (Person in Charge); Quality and Education Sister; and the Deputy Matron. We also spoke by telephone to the Chair of the Medical Advisory Committee.

The following records were examined during the inspection:

- UIC's current VTE policy and procedures;
- six patient's medical and nursing care records;
- practicing privileges agreements and related documentation;
- private doctor and surgical assistance staff lists; and
- medical staff training records;

Some areas for improvement identified at the previous unannounced inspection were not reviewed as part of this focused inspection and are carried forward to the next inspection.

The findings of the inspection were provided to the Person-in-Charge and the Quality and Education Sister at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection on 22, 23 and 24 January 2019

The previous inspection of the hospital was an unannounced inspection undertaken on 22, 23 and 24 January 2019. Following this inspection a QIP was issued to UIC which was completed and returned by Ms Graham, Chief Executive/Matron. This QIP will be validated by the inspectors at the next inspection.

6.2 Review of areas for improvement from the previous inspection on 22, 23 and 24 January 2019

This inspection focused solely on issues previously outlined in section 4.0. The areas for improvement from the last unannounced inspection undertaken on 22, 23 and 24 January 2019 and outlined in the attached QIP (Section 7) were not all reviewed as part of the inspection and some are carried forward to be validated at a subsequent inspection.

One area for improvement was not met in relation to medical governance and one area for improvement was partially met in respect to the management of VTE. These are stated for the second time within this report.

6.3 Inspection findings

6.3.1 Governance

We were informed that an independent consultant had been appointed to undertake an integrated governance review of UIC over a six week period, which commenced on 17 September 2019. We were told the governance review had completed and the action plan had been communicated to the Chairman of the Board of Directors on 31 October 2019. The Person-in-Charge and the Quality and Education Sister stated it had been agreed that the independent consultant would provide ongoing support to the governance department within UIC to implement the recommendations made in the action plan and would return in January 2020 to review the hospital's progress.

We were also informed that UIC have recruited one new full time staff member to strengthen the governance across the hospital. We were advised that the successful candidate had been recruited internally and the successful individual would not be released to take up their new governance responsibilities until the recruitment process has completed to appoint a replacement for their previous position in UIC. We were told that this recruitment process had not yet commenced.

6.3.2 Medical Governance

We reviewed arrangements supporting medical governance across the hospital and in particular the management of practising privileges for clinicians providing care and treatment in UIC and non-consultant grade doctors operating as surgical assistants.

Practising Privileges

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

We found that the hospital collects data to inform and underpin practising privileges arrangements on a spreadsheet and we reviewed the most recent version of this spreadsheet, updated 31 October 2019. We verified that 153 Consultants had submitted all of the required documentation which the hospital outlined was required to inform decisions relating to granting or maintaining practising privileges agreements. However, of the 153 Consultants recorded as having all the required documentation submitted to UIC, we noted that the professional indemnity cover for 13 had expired at the time of our inspection. A further 161 Consultants had submitted some of the required documentation to UIC, while 56 Consultants were recorded as not having submitted any of the required documentation. We found that significant progress had not been made to obtain the outstanding information required by the relevant legislation to inform decisions relating to practising privileges relating to granting or maintaining practising privileges agreements with a substantial proportion of the Consultants providing care and treatment in UIC. We were concerned about the significant delay in obtaining this information and were not assured that adequate safeguards were in place in this regard. We confirmed that Consultants who had not provided the required documentation relating to their practising privileges agreements continued to actively provided care and treatment in the hospital.

We were provided with a list of 31 clinicians who are working in UIC are doctors working in wholly private practice. On review of the documentation held in respect of this group of clinicians we found that not all of the required information had been sought and retained in respect of each of the records specified in Regulation 19 of The Independent Health Care Regulations (Northern Ireland) 2005. We found that three doctors working in wholly private practice were not were not included on the list of clinicians provided to us during the inspection. It was unclear to us if the hospital had any information retained in respect of these clinicians. We could not evidence that training records were available to confirm that doctors working in wholly private practice had completed the required mandatory training, in keeping with training requirements as advised by RQIA.

We were unable to determine if any of the clinicians, including clinicians working in wholly private practice, who are currently providing care and treatment in UIC had a current and up to date practising privileges agreement in place which was signed by both the clinician and the Ms Graham and which has been actively reviewed within the past two years.

We could not evidence that an agreed standard operating procedure to define the process for application, granting, maintenance and withdrawal of practising privileges was in place in the hospital.

We were not assured on discussion with staff and review of documentation that sufficient progress was being made in relation to information underpinning practising privileges arrangements, or actions taken to suspend practising privileges for individual clinicians who did not furnish UIC with the required information.

We were not assured that appropriate medical governance was in place within UIC particularly in relation the management and oversight of practising privileges.

Surgical Assistants

We enquired about the arrangements for non-consultant grade doctors operating as surgical assistants in UIC. We were informed that a number of non-consultant grade doctors continue to work as surgical assistants to support Consultants operating in UIC. We were advised that these doctors continue to work under the invitation of individual Consultants and are not employed by the hospital or have individual practising privileges agreements in place in relation to the work they undertake in UIC. On review of documentation provided by UIC it was noted that a majority of the non-consultant grade doctors operating as surgical assistants in UIC are doctors in training.

We were unable to evidence that robust governance arrangements were in place for the training and supervision of these doctors or to oversee their fitness and competence.

We were unable to determine a defined process in place regarding the practice of using surgical assistants within the hospital (either under a practising privileges agreement or through direct employment of non-consultant grade doctors by UIC). We were not assured that sufficient safeguards were in place to protect the safety and wellbeing of patients.

RQIA previously raised concerns regarding the use of surgical assistants at our unannounced inspection undertaken on 22, 23 and 24 January 2019 and at the Serious Concerns meeting on 17 July 2019. Actions to comply with Regulation 19 of The Independent Health Care Regulations (Northern Ireland) 2005 have been made within the Failure to Comply Notice.

6.3.3 Prevention and Management of VTE

During our inspection in January 2019 we found the hospital's policy and procedure relating to risk assessment and prevention of VTE was not in line with current best practice guidance. In addition our system of notifiable events informed us of incidents relating to the prevention and management of VTE. In October 2019, we requested further information from UIC in relation to VTE management and on receipt of this information we could not establish that the hospital had implemented a revised VTE policy and procedure, as required.

We examined the VTE policy and procedure currently in place in the hospital and found that this had been updated in line with best practice guidance. We were reassured by the presence of a refreshed VTE policy as the VTE policy provided on request to RQIA during October 2019 was a previous version that had not been updated. However, it is concerning that management failed to provide us, when requested, with the refreshed VTE Policy which was in place prior to our inspection on 4 November 2019.

Discussion with staff and a review of patient care records confirmed that a VTE risk assessment was available in each patient's file, however these risk assessments had not been consistently completed and we could not find evidence of systems in place to assure full compliance with the refreshed policy across the relevant clinical areas in the hospital. We highlighted the need to immediately commence the hospital's planned audit of implementation of the revised VTE policy and procedure. We will continue to monitor how this policy is embedded and assured through the hospital's governance arrangements during our future inspections to UIC.

7.0 Quality improvement plan (QIP)

Areas for improvement identified during the multidisciplinary inspection 22, 23 and 24 January 2019 are detailed in the attached QIP and some will be carried forward for review at a subsequent inspection. One area for improvement was not met in relation to medical governance and one area for improvement was partially met in respect to the management of VTE. These are stated for the second time.

Areas for improvement identified during this inspection are detailed in the attached QIP and subsumed in to the Failure to Comply Notice issued on 23 December 2019

Details of the inspection were discussed with the Theatre Manager (Person in Charge) and the Quality and Education Sister as part of the inspection process. The timescales commence from the date of inspection.

The Registered Provider/Manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action. It is the responsibility of the Registered Provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

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

7.1 Areas for improvement

Areas for improvement have been identified in which action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health (DOH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

7.2 Actions to be taken by the hospital

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The Registered Provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

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

Clinical and Organisational Governance	
Area for improvement 1 **Ref:** Regulation 17 **Stated:** First time **To be completed by:** 9 February 2020	The Registered Person shall ensure the following actions are addressed in relation to clinical and organisational governance: • undertake an urgent review of governance arrangements across the hospital; the governance structure, the role and function of committees and roles and responsibilities of key senior personnel; • the Board of Directors must demonstrate appropriate assurance that the person(s) undertaking the governance review has the appropriate skills, experience and competency to complete this work; • share the terms of reference for the above governance review with RQIA and confirm the proposed timescale for completion of the review; • dedicate 1 WTE staff member to work on governance across the hospital; • link with other independent healthcare providers by way of learning and support as work on the above governance review is progressing; • implement recommendations arising from the governance review through a detailed action plan; • share regular (monthly) updates on the progress of the above governance review with RQIA.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Medical Governance and Medical Staff Committee	
Area for improvement 2 **Ref:** Regulation 19 **Stated:** Second time **To be completed by:** 23 February 2020	The Registered Person shall ensure the following actions are addressed in relation to the medical governance: • urgently review and resolve the issue of medical practitioners working in the hospital, under the supervision of consultants, rather than under practising privileges arrangements; • ensure that all consultants with practising privileges have provided the required documentation, to maintain their ongoing practising privileges agreements; • share with RQIA the operating procedure which will be enacted if the required practising privileges documentation is not received, from individual consultants, by the agreed deadline;

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

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<tr><td></td><td>Action required to ensure compliance with this regulation was reviewed and will be progressed as part of the Failure to Comply Notice issued on 23 December 2019.</td></tr>
<tr><td rowspan="2">Area for improvement 3

Ref: Regulation 19

Stated: First time

To be completed by:
9 November 2019</td><td>The Registered Person shall address the following matters with respect of private doctors working in the hospital:

- the Responsible Officer (RO) should ensure he/she is assured that doctors working in a purely private capacity are completing annual appraisal with a suitable trained and skilled medical appraiser;
- the register of private doctors should be current and kept up to date; and
- all doctors working in a purely private capacity should ensure that they complete mandatory training in in keeping with the RQIA's training guidance, training records should be retained the hospital should retain up to date records of completion for this training.

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<tr><td>Action required to ensure compliance with this regulation was reviewed and will be progress as part of the Failure to Comply Notice issued on 23 December 2019.</td></tr>
<tr><td rowspan="2">Area for improvement 4

Ref: Standard 10.5

Stated: First time

To be completed by:
24 March 2019</td><td>The Registered Person shall address the following matters with respect to the oversight of all clinicians working in the hospital:

- the Responsible Officer (RO) should ensure closer links are established with ROs in the wider Health and Social Care (HSC) and that senior network; and
- develop a robust system for exchanging information with other relevant HSC or Independent Sector organisations when there are concerns or potential concerns regarding an individual clinician's practice.

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<tr><td>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.</td></tr>
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<tr><th colspan="2">Notifiable Events/Incidents</th></tr>
<tr><td rowspan="2">Area for improvement 5

Ref: Regulation 28 (1) (2)

Stated: First time

To be completed by:
9 January 2020</td><td>The Registered Person shall ensure the following actions are addressed in relation to the management of notifiable events/incidents:

• review the management of events/incidents to ensure that the system operates effectively and does not rely on a small number of key personnel;
• information relating to events/incidents must be provided to RQIA in a timely way. If the timescale for the provision of full information is not workable, robust interim information must be provided along with details of the initial assessment undertaken by UIC, the reason for the delay and the proposed date for provision of complete information;
• ensure that any information submitted to RQIA via email is on headed paper, signed, dated, version controlled (as applicable) and password protected; and
• implement recommendations arising from the above review of the management of events/incidents through a detailed action plan.</td></tr>
<tr><td>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.</td></tr>
<tr><th colspan="2">Management of Complaints</th></tr>
<tr><td rowspan="2">Area for improvement 6

Ref: Regulation 23

Stated: First time

To be completed by:
9 January 2020</td><td>The Registered Person shall ensure the following actions are addressed in relation to the management of complaints:

• review the hospital’s complaints management system using the Independent Sector Complaints Adjudication Service (ISCAS) risk assessment template, to benchmark the current complaints system against the guidance issued by ISCAS;
• implement recommendations arising from the above review of the complaints management system through a detailed action plan; and
• undertake a training needs analysis and ensure that all staff are appropriately trained in the management of complaints. The schedule for training, along with agreed timescale for completion should be shared with RQIA.</td></tr>
<tr><td>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.</td></tr>
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<tr><th colspan="2">Fluid Management</th></tr>
<tr><td rowspan="2">Area for improvement 7

Ref: Regulation 15 (1)

Stated: First time
time

To be completed by:
24 February 2019</td><td>The Registered Person shall address the following matters with respect to fluid management:

• The hospital's fluid management policy should be updated to include the amendment to NICE Clinical Guidance CG174 made by the Chief Medical Officer advising that Solution 18 is not available in Northern Ireland;
• the hospital's induction programme for the Resident Medical Officer (RMO) should be reviewed in respect of management and include clear information about the Northern Ireland context for prescribing, management and oversight of fluids;
• any identified discrepancy between the prescribed intravenous fluid and the fluid administered must be discussed with the prescribing clinician and reported in accordance with the hospital's adverse incident/event policy and procedure;
• review the system for monitoring a patient who is on fluid restriction to ensure that all staff are fully aware of and comply with the clinicians instructions, accurate nursing and medical records must be in place for all patients on active fluid management;
• ensure nursing and medical notes are completed contemporaneously and calculations are recorded to provide an accurate account of the patient's fluid intake and output; and
• develop a rolling audit programme to provide assurance of appropriate fluid management for all patients receiving care and treatment in the hospital.</td></tr>
<tr><td>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.</td></tr>
<tr><th colspan="2">Outpatients Department</th></tr>
<tr><td rowspan="2">Area for improvement 8

Ref: Regulation 21

Stated: First time

To be completed by:
9 November 2019</td><td>The Registered Person shall ensure that the following matters are addressed in relation to the Outpatients Department:

• retain a register of all patients attending the Outpatient Department; and
• develop and implement a patient record management system, which includes a contemporaneous note of each patients' medical history, all treatment provided, and all notes prepared by other health care professionals involved in their care.</td></tr>
<tr><td>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.</td></tr>
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<tr><th colspan="2">Policy/Guidance and Best Practice</th></tr>
<tr><td rowspan="2">Area for improvement 9

Ref: Regulation 15 (1) (b)

Stated: Second time

To be completed by:
4 February 2020</td><td>The Registered Person shall address the following matters with respect to the management of venous thromboembolism (VTE):

• review the current VTE management policy and ensure that it is in keeping with NICE guideline [NG89];
• ensure that the MAC contributes to and approves the hospital's updated VTE policy;
• ensure that VTE risk assessments are undertaken and documented in respect of all patients admitted for surgical procedures; and
• include VTE in the hospital's rolling programme of audit, to provide assurance of best practice in implementation of VTE risk assessments and related actions.

Ref: 6.3.3</td></tr>
<tr><td>Response by Registered Person detailing the actions taken:
he VTE policy has been reviewed to reflect NICE guideline (NG89), and ratified by the Medical Advisory Committee.
Medical (July 2019) and nursing VTE risk assessments are undertaken and documented for all patients admitted.
Completion of VTE risk assessment forms is subject to ongoing audit.</td></tr>
<tr><th colspan="2">International Dysphagia Diet Standardisation Initiative (IDDSI)</th></tr>
<tr><td rowspan="2">Area for improvement 10

Ref: Standard 9.1

Stated: First time

To be completed by:
24 April 2019</td><td>The Registered Person shall address the following issues in relation to IDDSI and the implementation of new guidance:

• review previous decision making in relation to the implementation of IDDSI;
• ensure that all relevant staff are aware of IDDSI and the implications for patients attending or being admitted to the hospital who may have swallowing difficulties or require modified diets; and
• ensure all staff receive training in relation to the application of the IDDSI guidance which is relevant to their roles and responsibilities.</td></tr>
<tr><td>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.</td></tr>
<tr><th colspan="2">Policy Development/Guidance Documents</th></tr>
<tr><td>Area for improvement 11

Ref: Standard 19

Stated: First time</td><td>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</td></tr>
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To be completed by: 24 April 2019	notices in a timely manner; • ensure the review process involves a group of appropriately qualified staff and is not delegated to one person; and • retain a record of the decisions made and outcomes agreed or recommended following the review of each guidance document. This note should clearly outline the decision making process(es). Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Endoscopy/Estates	
Area for improvement 12 **Ref**: Standard 21.2 **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall implement in full the key findings advised by DoH Health Estates following their audit of the hospital's decontamination equipment, facilities and processes. Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Area for improvement 13 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall review the team structures within the estates department to ensure the operational roles and responsibilities outlined in the relevant Health Technical Memoranda (HTM's) in relation to the premises' mechanical and electrical services (including decontamination) are fully met. Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Laser safety	
Area for improvement 14 **Ref:** Regulation 18 (2) (a) **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall ensure that records are retained to evidence that all clinical authorised operators using the laser have completed training in keeping with RQIA training guidance for cosmetic laser services. Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Area for improvement 15 **Ref:** Standards 48.6 **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall implement a system to ensure that an authorised operator does not operate the hospital's laser equipment until they have signed a declaration to confirm that they have read and will abide by the Local Rules. Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.

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<tr><td rowspan="2">Area for improvement 16

Ref: Standards 48.17

Stated: First time

To be completed by:
24 April 2019</td><td>The Registered Person shall ensure that the Laser Protection Supervisor (LPS) informs the Laser Protection Advisor (LPA) that one set of protective eyewear available has a higher level of protection than that stated in the Local Rules. The outcome of the discussion with the LPA should be actioned and documented in the Local Rules. The Local Rules must accurately reflect the eyewear required for the laser equipment and these must be available for use.</td></tr>
<tr><td>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.</td></tr>
<tr><td rowspan="2">Area for improvement 17

Ref: Standards 48.10

Stated: First time

To be completed by:
24 April 2019</td><td>The Registered Person shall ensure that the Laser Protection Supervisor (LPS) confirms the precise exposure (to include all three parameters frequency/single pulse energy/total energy) is recorded in the laser register on each occasion the hospital's laser equipment is operated.</td></tr>
<tr><td>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.</td></tr>
<tr><td colspan="2">Medicines Management</td></tr>
<tr><td rowspan="2">Area for improvement 18

Ref: Regulation 15 (7)

Stated: First time

To be completed by:
24 April 2019</td><td>• The Registered Person shall ensure that the following matters are address in relation antimicrobial/antibiotic stewardship:
•
• ensure that an anti-microbial/antibiotic stewardship policy is developed in keeping with NICE guideline [NG15];
• ensure the Medical Staff Committee and relevant clinicians/ clinical groups actively contribute to the development of the policy;
• ensure the policy clearly describes the prophylactic medications that may be prescribed by clinicians practising in the hospital; and
• ensure that a rolling audit programme is developed to provide assurance that the policy is being adhered to.</td></tr>
<tr><td>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.</td></tr>
<tr><td colspan="2">Care Pathway</td></tr>
<tr><td>Area for improvement 19

Ref: Regulation 21 (1)

Stated: First time

To be completed by:
24 April 2019</td><td>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;</td></tr>
</table>

	• confirmation that an assessment tool is used by the consulting surgeon to determine the suitability of each patient for surgery and a copy is provided to ward staff as part of the admission process; and • a system should be in place to review and audit the admission procedures to ensure that they are effective and robust.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Area for improvement 20 **Ref**: Standard 6.9 **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall ensure that discharge letters provide accurate detail of the specific procedure undertaken and/or treatment provided to the patient. Discharge letters provided to all parties should be legible.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.
Area for improvement 21 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 24 April 2019	The Registered Person shall ensure that comprehensive records are maintained for each patient receiving care and treatment in the hospital: • care plans should be written with the involvement of the patient wherever practicable • care records should provide clear evidence of the care planned, the decisions made, the care delivered and the information shared. (NMC The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, 2018) • all care records should be legible; accurately capture all relevant information; and include the full details of all procedures undertaken
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a subsequent inspection.

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

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

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

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