Announced Care Inspection Report
4 and 5 December 2017

Ulster Independent Clinic

Type of Service: Independent Hospital – Surgical Services
Address: 245 Stranmillis Road, Belfast BT9 5JH
Tel No: 0289066 1212
Inspectors: Winifred Maguire & Stephen O'Connor

Accompanied by:

RQIA's Medical Director, Dr Lourda Geoghegan
RQIA's Chief Executive, Ms Olive Macleod (5 December 2017)
RQIA's Medical Physics Advisor, Dr Ian Gillan (5 December 2017)

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 from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

The Ulster Independent Clinic is registered as an Independent Hospital (IH) with the following categories of care: Acute Hospital (AH), Prescribed Techniques Endoscopy PT (E), Prescribed Techniques Laser PT (L), and Acute Hospital Day Services AH (DS) and Private Doctor (PD).

The hospital is registered for 70 overnight beds and has a day procedure unit. The establishment provides a wide range of services and treatments, ranging from outpatient medical and surgical consultations; diagnostic tests and investigations; simple surgical day case procedures; and paediatric services to major surgical interventions such as joint replacement surgery. A one stop breast care clinic service is provided and a limited chemotherapy service.

Laser equipment (in use 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

3.0 Service details

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

4.0 Inspection summary

An announced inspection took place on 4 and 5 December 2017 from 10.00 to 17.30 and 10.05 to 17.00 respectively.

Dr Ian Gillan, RQIA's Medical Physics Advisor, accompanied the inspectors to review the laser safety arrangements for the laser service; the findings and report of Dr Gillan are appended to this report.

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, Social Services and Public Safety (DHSSPS) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

The inspection assessed progress with any areas for improvement identified since the last medicines management inspection and to determine if the establishment was delivering safe, effective and compassionate care and if the service was well led.

Examples of good practice were evidenced in all four domains. These related to: patient safety in respect of staff training and development; recruitment; safeguarding; the provision of surgical services; resuscitation arrangements and the management of medical emergencies; and the environment. Other examples included: the management of the patients' care pathway; communication; records management, practising privileges arrangements and engagement to enhance the patients' experience.

Three areas requiring improvement were identified against the standards in relation to ensuring laser documentation is devised in accordance to the laser equipment in use; the strengthening and developing of infection prevention control arrangements in accordance with the evolving challenges in this area experienced by all care providers; and the devising of definitions for the quality indicators used as part of the quality assurance systems to facilitate meaningful benchmarking.

Patients and relatives who spoke with the inspectors were very satisfied with the services provided in Ulster Independent Clinic. Comments provided included the following:

- "Staff constantly checking I'm ok."
- "I was fully informed in all decisions about my surgery."
- "It's marvellous in every way."
- "Excellent service."
- "I'll be recommending it to all my friends who need surgery."
- "Everyone from the cleaner to the surgeon was super."
- "They offered me constant reassurance when my son was in theatre."

The findings of this report will provide the establishment with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	3

Details of the Quality Improvement Plan (QIP) were discussed with Ms Diane Graham, registered person and Sister Wendy McCaughern, Quality and Education Sister as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection dated 30 March 2017

No further actions were required to be taken following the most recent inspection on 30 March 2017.

5.0 How we inspect

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

- notifiable events since the previous care inspection
- duty calls
- the registration status of the establishment
- written and verbal communication received since the previous care inspection
- previous variation did not result in a QIP
- the previous care inspection report
- submitted complaints declaration

Questionnaires were provided to patients and staff prior to the inspection by the establishment on behalf of RQIA. Returned completed patient and staff questionnaires were also analysed prior to the inspection.

A poster informing patients that an inspection was being conducted was displayed.

During the inspection the inspectors met with three patients and four relatives. The following staff were also spoken with during the inspection:

- Ms Diane Graham, registered person
- Sister Wendy McCaughern, quality and education sister
- the infection prevention control lead
- the theatre manager
- two theatre nurses
- a theatre sister acting as the LPS for the laser service
- a recovery sister
- two breast care nurses
- a paediatric nurse
- a sister at ward level
- a physiotherapist
- two domestic support staff
- briefly with a paediatric anaesthetist

A tour of some areas of the premises was also undertaken.

A sample of records was examined during the inspection in relation to the following areas:

- staffing
- recruitment and selection
- surgical services

- laser safety
- safeguarding
- resuscitation and management of medical emergencies
- infection prevention and control and decontamination
- clinical record recording arrangements
- management of patients
- patient information and decision making
- practising privileges arrangements
- management and governance arrangements
- maintenance arrangements

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 19 September 2017

The most recent inspection of the establishment was an unannounced medicines management inspection. There were no areas for improvement made as a result of the inspection.

6.2 Review of areas for improvement from the last care inspection dated 30 March 2017

There were no areas for improvement made as a result of the last care inspection.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Staffing

A review of duty rotas, discussion with staff and completed staff and patient questionnaires demonstrated that there was sufficient staff in various roles to fulfil the needs of the hospital and patients. There is a multi-professional team which includes consultant surgeons, consultant physicians, anaesthetists, nurses, radiographers, allied health professionals, and specialist laboratory staff with specialist skills and experience to provide a range of hospital services including surgical services. A resident medical officer is available on site to provide medical cover.

Review of the duty rotas confirmed that there was adequate staff in place to meet the assessed needs of the patients accommodated at the time of inspection.

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

Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place. Staff confirmed they felt supported and involved in discussions about their personal development. Review of a sample of four evidenced that appraisals had been completed on an annual basis.

There were systems in place for recording and monitoring all aspects of staff ongoing professional development, including specialist qualifications and training.

Arrangements were in place to ensure that all health and social care professionals are aware that they are accountable for their individual practice and adherence to professional codes of conduct.

Ms Graham and Sister McCaughern confirmed that a robust system was in place to review the professional indemnity status of all staff who require individual indemnity cover. Review of personnel files confirmed that medical practitioners had appropriate professional indemnity insurance in place and received the required annual appraisals.

The hospital affords staff opportunities to undertake specialist qualifications such as intravenous medication administration, peripheral cannulation, urinary catheterisation and 'right patient right blood'. Ms Cathcart explained that the hospital promoted individual continuing professional development (CPD) plans. It was confirmed professional development opportunities are afforded to all grades of staff in a fair and equitable manner.

There was a process in place to review the registration details of all health and social care professionals.

Five personnel files of medical practitioners were reviewed and evidenced the following:

- confirmation of identity
- current registration with the General Medical Council (GMC)
- appropriate professional indemnity insurance
- appropriate qualifications, skills and experience
- ongoing professional development and continuing medical education that meet the requirements of the Royal Colleges and GMC
- ongoing annual appraisal by a trained medical appraiser

The inspectors confirmed that each medical practitioner has an appointed responsible officer.

Recruitment and selection

It was confirmed that a number of staff have been recruited since the previous inspection. A review of a sample of three of the personnel files for these staff demonstrated that all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations Northern Ireland) 2005 has been sought and retained.

There was a recruitment policy and procedure available. The policy was comprehensive and reflected best practice guidance.

Surgical services

The hospital has a wide range of comprehensive policies and procedures in place to ensure that safe and effective care is provided to patients 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.

Review of the patient care records and discussion with staff and patients confirmed that the anaesthetist who administers 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

Discussion with staff, patients and relatives confirmed that the surgeon met with the patient prior to the operation to discuss the procedure and obtain informed consent.

There is an identified member of nursing staff, with theatre experience, in charge of the operating theatre at all times. A permanent record is retained of the name of nurse in charge of each theatre.

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

On discussion staff confirmed that the surgical checklist based on the World Health Organisation (WHO) model is used in the hospital. Completion of surgical checklists is audited as part of the hospitals comprehensive clinical governance systems. Review of the audits confirmed that a high compliance rate is achieved.

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 following areas of theatre practice were discussed with the theatre manager and theatre staff:

- prevention of intra –operative hypothermia
- intra-operative fluid management
- massive blood loss in theatre
- nurse in charge of theatre
- anaesthetist’s role
- regional labelling of invasive lines and tubes
- cleaning of theatres including deep cleaning

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

A review of the surgical register of operations which is maintained for all surgical procedures undertaken in the hospital found that it contained all of the information required by legislation.

The staff confirmed a theatre users group – forum meet on a bi-monthly basis.

Laser Safety

A laser safety file was in place which contains information in relation to laser equipment. A new laser machine had been installed in August 2017 and the previous machine removed from use. The laser information available was in relation to the previous laser machine. An area of improvement has been identified against the standards to ensure all laser documentation including the local rules and the risk assessment has been updated to reflect use of the new laser machine. The local rules should be signed as read and understood by all authorised operators.

There was written confirmation of the appointment and duties of a certified laser protection advisor (LPA) which is reviewed on an annual basis. The service level agreement between the establishment and the LPA was reviewed and this expires on 31 March 2020.

Laser surgical procedures are carried out by consultant urologists in accordance with medical treatment protocols produced by them. Systems are in place to review the medical treatment protocols on an annual basis.

Two different lists of clinical and non-clinical authorised operators was in place, it was advised to have one list of current authorised operators.

It was confirmed authorised operators had ‘use of the laser application’ training. The core of knowledge training certificates for the authorised operators (surgeons) was reviewed and it was agreed that the hospital should discuss the future training plan with their LPA.

When the laser equipment is in use, the safety of all persons in the controlled area is the responsibility of the laser protection supervisor (LPS). Arrangements are in place for another authorised operator to deputise for the LPS in their absence, who is suitably skilled to fulfil the role. Discussion with the LPS confirmed that systems are in place to ensure other authorised operators are aware who is the LPS on duty.

The environment in which the laser equipment is used was found to be safe and controlled to protect other persons while treatment is in progress. The controlled area is clearly defined and not used for other purposes, or as access to areas, when surgery is being carried out.

The doors to the theatre suite are controlled when the laser equipment is in use but can be opened from the outside in the event of an emergency.

The laser equipment is operated using a key. Arrangements are in place for the safe custody of the laser key when not in use.

Laser safety warning signs are displayed when the laser equipment is in use and removed when not in use.

Protective eyewear was available as outlined in the local rules for laser technicians/surgical assistants if required. However as stated previously the local rules require to be devised in accordance with the new laser machine to include the protective eyewear outlined for use with this machine.

The hospital had a laser surgical register which is completed every time the equipment is operated and includes:

- the name of the person treated
- the date
- the operator
- the treatment given
- the precise exposure
- any accident or adverse incident

A review of the laser surgical register during the inspection found it to be comprehensively completed.

There are arrangements in place to service and maintain the laser equipment in line with the manufacturer's guidance. The most recent service report was reviewed as part of the inspection process.

The laser safety file contained MHRA guidance on the safe use of laser systems dated 2008, it was agreed this should be replaced with the more recent 2015 version.

Safeguarding

Staff spoken with were aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified, including who the nominated safeguarding lead was.

Review of records demonstrated that all staff in the establishment had received training in safeguarding children and adults as outlined in the Minimum Care Standards for Independent Healthcare Establishments July 2014, and in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016).

It was confirmed further safeguarding training had been arranged for the adult safeguarding leads and champion in April 2018.

Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. The policy included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The relevant contact details for onward referral to the local Health and Social Care Trust should a safeguarding issue arise were included.

It was confirmed that copies of the regional policy entitled 'Co-operating to Safeguard Children and Young People in Northern Ireland' (March 2016) and the regional guidance document entitled 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015) were both available for staff reference.

Resuscitation and management of medical emergencies

A review of medical emergency arrangements evidenced that emergency medicines were provided in keeping with the British National Formulary (BNF), and that emergency equipment as recommended by the Resuscitation Council (UK) guidelines was retained. A robust system was in place to ensure that emergency medicines and equipment do not exceed their expiry date. There was an identified individual with responsibility for checking emergency medicines and equipment. Emergency trollies located in Level 2 ward area and theatre/recovery area were reviewed and found to contain all the necessary equipment. It was confirmed that the emergency medicines are checked by the hospital pharmacist who then seals and tags the emergency medicine boxes.

A review of training records and discussion with staff confirmed that staff have undertaken adult and paediatric basic life support training and updates and some staff had undertaken immediate life support training and updates. There is always at least one staff member with advanced life support training on duty at all times. It was confirmed the resident medical officer has undertaken advanced life support training for adults and children.

Staff confirmed that they had undertaken scenario medical emergency training provided by anaesthetists which they had found very valuable.

Discussion with staff in relation to the arrangements regarding patients with a “Do Not Resuscitate” (DNR) order in place 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.

Discussion with staff demonstrated that they have a good understanding of the actions to be taken in the event of a medical emergency and the location of medical emergency medicines and equipment.

A wide range of policies and procedures were in place for the management of medical emergencies which reflected best practice guidance. These included:

- patient requiring portable ventilation from Ulster Independent Clinic to intensive care unit using Northern Ireland critical care transfer service (NICCATS)
- management of a deteriorating patient.
- management of chest pain, acute ST elevation
- advance directives
- transferring a patient to intensive care unit (ICU)

Infection prevention control and decontamination procedures

There were clear lines of accountability for infection prevention and control (IPC). The establishment has a designated IPC lead nurse. The inspectors spoke with the IPC lead for the hospital who demonstrated a clear understanding of her role and responsibilities and confirmed she is a member of the infection prevention society and attends meetings three times a year.

There was a range of information for patients and staff regarding hand washing techniques.

Arrangements were in place to ensure the decontamination of equipment and reusable medical devices in line with manufacturer's instructions and current best practice. Staff confirmed single use equipment is used where possible.
Staff have been provided with IPC training commensurate with their role.

Discussion with staff confirmed they had a good knowledge and understanding of IPC measures.

A range of IPC audits has been carried out including:

- environmental
- hand hygiene
- surgical site infection

The compliance rate was noted to be very high and an action plan was in place for areas of non-compliance.

Patients spoken with confirmed staff are diligent in carrying out hand washing when delivering care. Patients also confirmed they were screened for infections such as Methicillin-resistant Staphylococcus aureus (MRSA) prior to admission to the hospital for surgery.

Discussion with staff and management on the evolving challenges in relation to the area of IPC, noted that whilst there were very good IPC arrangements in operation throughout the hospital, the strengthening and further development of these arrangements is required to meet the challenges ahead.

An area of improvement against the standards was identified to strengthen IPC arrangements as follows:

- Develop a risk assessment/screening tool for Carbapenem-Resistant Enterobacteriaeaca(CRE) and Carbapenem-producing Enterobacteriaeaca (CPE).
- Review the outbreak of an infection plan/policy to be more specific on the roles and responsibilities of staff within the hospital in the event of an outbreak.
- A clear definition for surgical site infection should be established.
- The hospital should explore linking with the regional joint replacement surgical site infection surveillance register, thus allowing for meaningful benchmarking.

It was confirmed the hospital has been proactive in arranging a multi-professional (including the pharmacy team) review of the Antimicrobial Policy in early 2018.

The hospital was found to be clean, tidy and well maintained.

There were a range of IPC policies and procedures in place which were located within an IPC manual.

Environment

The environment was maintained to a high standard of maintenance and décor. The hospital is undergoing renovations in relation to the building of a new outpatients department and endoscopy suite and a variation of registration application has been submitted to RQIA on this matter. Ms Graham confirmed that the first phase of the building work is hoped to be completed

by late January 2018 and all work completed by April 2018. RQIA variation of registration inspections will be undertaken in relation to the renovation works prior to patient use.

Detailed cleaning schedules were in place for all areas which were signed on completion. A colour coded cleaning system was in place.

A review of documentation and discussion with Ms Graham demonstrated that arrangements are in place for maintaining the environment.

A legionella risk assessment has been undertaken and water temperatures are monitored and recorded as recommended.

A fire risk assessment had been undertaken and staff confirmed fire training and fire drills had been completed. Staff demonstrated that they were aware of the action to take in the event of a fire.

Patient and staff views

Five patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm and were very satisfied with this aspect of care. No comments were included in submitted questionnaire responses.

Five staff submitted questionnaire responses. All indicated that they felt that patients are safe and protected from harm and were very satisfied with this aspect of care. Staff spoken with during the inspection concurred with this. No comments were included in submitted questionnaire responses.

Areas of good practice

There were examples of good practice found in relation to staff recruitment; induction; training; supervision and appraisal; safeguarding; surgical services; resuscitation and management of medical emergencies; radiology and the environment.

Areas for improvement

All laser documentation including the local rules and the risk assessment should be updated to reflect use of the new laser machine. The local rules should then be signed as read and understood by all authorised operators.

Strengthen IPC arrangements as follows:

- Develop a risk assessment/screening tool for Carbapenem-Resistant Enterobacteriaeaca (CRE) and Carbapenem-producing Enterobacteriaeaca (CPE).
- Review the outbreak of an infection plan/policy to be more specific on the roles and responsibilities of staff within the hospital in the event of an outbreak.
- Clear definition for surgical site infection should be established.
- The hospital should explore linking with the regional joint replacement surgical site infection surveillance register, thus allowing for meaningful benchmarking.

	Regulations	Standards
Total number of areas for improvement	0	2

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Care pathway

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. Copies of the patient guide are made available to all patients following admission.

Four patient records reviewed found that the care records contained comprehensive information relating to pre-operative, peri-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
- 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

Patients and relatives 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:

- "Well informed."
- "Pain well managed."
- "Definitely kept me well informed."
- "Given a lot of information and an opportunity to ask as many questions as I wanted to."
- "Second to none"

Records

Systems were in place to audit the patient care records as outlined in the establishments quality assurance programme. A number of audits relating to patient care records were reviewed and an excellent compliance rate was noted.

Information was available for patients on how to access their health records, under the Data Protection Act 1998.

The establishment is registered with the Information Commissioner's Office (ICO).

Discussion with staff confirmed they had a good knowledge of effective records management. The establishment has a range of policies and procedures in place for the management of records which includes the arrangements for the creation, use, retention, storage, transfer, disposal of and access to records.

The establishment also has a policy and procedure in place for clinical record keeping in relation to patient treatment and care which complies with (GMC) guidance and Good Medical Practice and other professional bodies' guidance.

The management of records within the establishment was found to be in line with legislation and best practice.

Discharge planning

The hospital has a discharge policy and procedure in place.

It was confirmed there are well developed discharge planning arrangements in place that require full engagement with patients and/or their representatives. The hospital liaison sisters' co-ordinates discharge of patients with the involvement of general practitioners and other professionals to ensure their ongoing care and treatment. A patient confirmed the hospital liaison sister had visited him and explained the discharge process and referrals to other services. The patient stated he was very reassured by the consultation and felt fully involved in his arrangements for discharge.

A discharge summary and plan is completed prior to the patient leaving the hospital. A letter is provided to the patient's general practitioner to outline the care and treatment provided within the hospital.

There are robust systems in place to ensure that agreed discharge arrangements are recorded and co-ordinated with all services that are involved in the patient's ongoing care and treatment.

Patient and staff views

All patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them and were very satisfied with this aspect of care. No comments were included in submitted questionnaire responses.

All submitted staff questionnaire responses indicated that they felt that patients get the right care, at the right time and with the best outcome for them and were very satisfied with this aspect of care. Staff spoken with during the inspection concurred with this. The following comment was provided:

- "Having been a patient myself, my cancer would not have been detected had it not of been for the rapid response of staff and matron."

Areas of good practice

There were examples of good practice found in relation to completion of clinical records, the arrangements for records management and ensuring effective communication between patients and staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Dignity, respect and rights

Discussion with management and staff regarding the consultation and treatment process confirmed that patient's modesty and dignity is respected at all times. In-patients and day patients are accommodated in single rooms with en-suite facilities. Outpatients are provided with modesty screens and curtains as appropriate.

It was confirmed through the above discussion and observation that patients are treated in accordance with the DHSSPS standards for Improving the Patient & Client Experience.

Patients meet with the medical practitioner undertaking the treatment and are fully involved in decisions regarding their treatment. Patients' wishes are respected and acknowledged by the establishment.

Discussion with patients, staff and review of patient care records confirmed that patients are treated and cared for in accordance with legislative requirements for equality and rights. Patient care records were observed to be stored securely in the nurses' office.

Staff were observed treating patients and their relatives with compassion, dignity and respect. Discussion with patients confirmed this. Comments received from patients included:

- "Everyone was so kind to me immediately put me at my ease."
- "Always conscious of my dignity when they were looking after me."
- "All staff were polite and courteous to me."

All patients and/or their representatives are asked for their comments in relation to the quality of treatment provided, information and care received.

Discussion with patients and relatives confirmed they have the opportunity to comment on the quality of care and treatment provided, including their interactions with staff who work within the hospital.

Review of patient care records and discussion with patients, relatives and staff confirmed that treatment and care is planned and developed with meaningful patient involvement; facilitated and provided in a flexible manner to meet the assessed needs of each individual patient.
A policy and procedure was in place in relation to confidentiality which included the arrangements for respecting patient's privacy, dignity and providing compassionate care and treatment.

Breaking bad news

The hospital has a policy and procedure for delivering bad news to patients and/or their representatives which is accordance with the Breaking Bad News Regional Guidelines.

The hospital retains a copy of the Breaking Bad News Regional Guidelines 2003 and this is accessible to staff.

The inspectors spoke with two breast care nurses who confirmed that bad news is delivered to patients and/or their representatives by professionals who have experience in communication skills and act in accordance with the hospital's policy and procedure. They confirmed they had undertaken advanced communication training.

Where bad news is shared with others, staff confirmed that consent must be obtained from the patient and this is documented in the patient's records.

Following a patient receiving bad news, future treatment options are discussed fully with the patient and documented within their individual care records.

With the patient's consent, information will be shared with the patient's general practitioner and/or other healthcare professionals involved in their ongoing treatment and care.

Patient consultation

The establishment obtains the views of patients and/or their representatives 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.

A review of a random selection of completed questionnaires 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:

- "Very happy with the service."
- "Very kind and competent staff."
- "Staff were very informative and I felt reassured."
- "I like that I can have my teddy in bed."(child)
- "Theatre staff, they were all amazing."
- "Very attentive and lovely experience."
- "Excellent care!"
- "Extremely professional."

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 within the establishment and on the establishment's website.
Discussion with Ms Graham and Mrs Cathcart confirmed that comments received from patients and/or their representatives are reviewed by senior management within the establishment and an action plan is developed and implemented to address any issues identified and used to improve the delivery of service.

Patient and staff views

All patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care and were very satisfied with this aspect of care. No comments were included in submitted questionnaire responses.

All submitted staff questionnaire responses indicated that they felt that patients are treated with dignity and respect and are involved in decision making affecting their care and were very satisfied with this aspect of care. Staff spoken with during the inspection concurred with this. The following comment was provided:

- "100%."

Areas of good practice

There were examples of good practice found throughout the inspection in relation to maintaining patient confidentiality, ensuring the core values of privacy and dignity were upheld and providing the relevant information to allow patients to make informed choices.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Management and governance arrangements

There was a clear organisational structure within the hospital and staff were able to describe their roles and responsibilities and were aware of who to speak to if they had a concern. Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Ms Graham has overall responsibility for the day to day management of the hospital.

Systems were in place to ensure that the quality of services provided by the hospital is evaluated on an annual basis and discussed with relevant stakeholders. The hospital has a robust clinical governance system involving all areas of the hospital service.

A clinical and quality governance strategy dated September 2017 was in place and includes review of policies, introduction of intranet, complete Caspe Health Knowledge Systems (CHKS) survey 2017, hospital audit programme, clinical quality indicators, surgical safety checklist, comment forms, complaints, mandatory training, appraisals ,further development of paediatric plan, and introduction of PEWS(paediatric early warning signs) checks for paediatrics.

A range of committees supports the implementation of governance arrangements in including:

- operational management group – which meet monthly
- medical staff committee – which meet bi monthly
- theatre users group – which meet bi monthly
- departmental meetings – which monthly
- clinical governance and medical audit sub-committee- which meet quarterly.

As stated a wide range of clinical quality indicators are in place and were reported on in 2016 and a comparison made with results in 2015.

On discussion it was noted that there was not a clear definition for each clinical quality indicator and it was advised the development of definitions would allow for more meaningful benchmarking. An area of improvement has been identified on this matter.

Staff confirmed Ms Graham operates ‘an open door policy’ for staff.

Policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, dated and systematically reviewed on a three yearly basis. Staff spoken with were aware of the policies and how to access them.

Arrangements were in place to review risk assessments.

A copy of the complaints procedure was available in the hospital. Staff demonstrated a good awareness of complaints management. A complaints questionnaire was forwarded by RQIA to the hospital for completion. The evidence provided in the returned questionnaire and a review of complaints records indicated that complaints have been managed in accordance with best practice.

Ms Graham, Sister McCaughern and staff confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals. If required an action plan is developed and embedded into practice to address any shortfalls identified during the audit process. A formal audit programme was in place and included:

- complaints
- accidents and incident
- completion of the surgical safety checklist
- completion of day patient surgical safety checklist
- completion of endoscopy safety checklist
- pre-operative visiting by theatre staff
- infection prevention and control
- sharps awareness
- controlled drugs

An audit had been completed in 2015/16 on compliance with the venous thromboembolism (VTE) regional risk assessment. It was advised to carry out a further audit to ensure improvement has been sustained. Ms Graham gave assurances on this matter.
A system was in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies as appropriate. A system was also in place to ensure that urgent communications, safety alerts and notices are reviewed and where appropriate, made available to key staff in a timely manner.

The establishment has arrangements in place to monitor the competency and performance of all staff and if appropriate refer individuals to the relevant professional regulatory bodies in accordance with guidance.

Ms Graham outlined the process for granting practising privileges and confirmed medical practitioners meet with her prior to privileges being granted by the medical staff committee.

Four medical practitioner's details were reviewed and confirmed that there was a written agreement between each medical practitioner and the establishment setting out the terms and conditions of practising privileges which has been signed by both parties.

There are systems in place to review practising privileges agreements every two years.

Ulster Independent Clinic has a policy and procedure in place which outlines the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges.

A whistleblowing/raising concerns policy was available. Discussion with staff confirmed that they were aware of whom to contact if they had a concern.

Ms Graham demonstrated a clear understanding of her role and responsibility in accordance with legislation. Information requested by RQIA has been submitted within specified timeframes. It was confirmed that the statement of purpose and patient's guide are kept under review, revised and updated when necessary and available on request.

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

Observation of insurance documentation confirmed that current insurance policies were in place.

Patient and staff views

All patients who submitted questionnaire responses indicated that they felt that the service is well led and were very satisfied with this aspect of the service. No comments were included in submitted questionnaire responses.

All submitted staff questionnaire responses indicated that they felt that the service is well led and were very satisfied with this aspect of the service. Staff spoken with during the inspection concurred with this. No comments were included in submitted questionnaire responses.

Areas of good practice

There were examples of good practice found in relation to the management of complaints and incidents; practising privileges arrangements; quality improvement and governance arrangements; and maintaining good working relationships.

Areas for improvement

A clear definition for each clinical quality indicator should be devised to allow for more meaningful benchmarking

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Diane Graham, registered person and Ms Wendy Cathcart, 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 including possible prosecution for offences. 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 where action is required to ensure compliance with 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, Social Services and Public Safety (DHSSPS) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

7.2 Actions to be taken by the service

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 Minimum Care Standards for Independent Healthcare Establishments (2014)	
Area for improvement 1 **Ref**: Standard 48.21 **Stated:** First time **To be completed by:** 4 February 2018	The registered person shall ensure all laser documentation including the local rules and the risk assessment should be updated to reflect use of the new laser machine. The local rules should then be signed as read and understood by all authorised operators. Ref: 6.4
	Response by registered person detailing the actions taken: Arrangements have been made to complete this in conjunction with our Laser Protection Advisor.
Area for improvement 2 **Ref**: Standard 20.2 **Stated:** First time **To be completed by:** 4 March 2018	The registered person shall strengthen IPC arrangements as follows: • Develop a risk assessment/screening tool for Carbapenem-Resistant Enterobacteriaeaca (CRE) and Carbapenem-producing Enterobacteriaeaca (CPE). • Review the outbreak of an infection plan/policy to be more specific on the roles and responsibilities of staff within the hospital in the event of an outbreak. • A clear definition for surgical site infection should be established. • The hospital should explore linking with the regional joint replacement surgical site infection surveillance register, thus allowing for meaningful benchmarking. Ref: 6.4
	Response by registered person detailing the actions taken: The Infection Prevention Sister is progressing the above matters and considers a completion date of 4 June will be necessary.
Area for improvement 3 **Ref**: Standard 9.7 **Stated:** First time **To be completed by:** 4 March 2018	The registered person shall devise a clear definition for each clinical quality indicator to allow for more meaningful benchmarking. Ref: 6.7
	Response by registered person detailing the actions taken: This is being actioned by the Quality and Education Department.

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

5th December 2017

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Laser Protection Report

Ulster Independent Clinic, 245 Stranmillis Road, Belfast

Introduction

Further to the inspection of the above premises earlier today this report summarises the main laser protection aspects where improvement may be required. The findings are based on the requirements of current legislation, relevant guidance notes and European Standards.

Findings and Comments

Arrangements for advice from a Laser Protection Adviser.
UIC have in place a contract for the period April 2017 to March 2020 (signed by UIC in November 2017) for Mr Philip Loan, BHSCT to act as the Laser Protection Adviser (LPA). Unfortunately, the apparent lapse in contract earlier in the year coincided with UIC purchasing a new laser in August 2017. This may have contributed to the fact that many of the documents within the laser safety file refer to the previous laser system or are now out of date.

Current versions of the following documents should be forwarded to RQIA for their consideration:-

(1) Recent report from the clinic's LPA
(2) Local Rules for the new laser system
(3) Risk assessment for the use of the new laser
(4) A valid LPA certificate

Protective Eyewear
Laser Aid disposable eye shields are used to provide protection for the patient, however these are not referred to in the Local Rules (for the previous laser system). In addition, UIC has recently ordered additional protective eyewear for the staff.

All laser protective eyewear available for both staff and patients should be approved by the clinics LPA and details of the approved eyewear detailed in the Local Rules.

MHRA Guidance Document
The laser safety file contains the MHRA guidance document on the safe use of laser systems dated 2008, this should be replaced with the more recent 2015 version.

Authorised Laser Users list
The laser safety file contains two differing list of authorised laser users

Core of Knowledge Training
The following point from last year's report appears not to have been fully addressed:-

'The core of knowledge training certificates for the surgeons were reviewed and it was agreed that the clinic should discuss the future training plan with their LPA.'

Ian Gillan

Dr Ian Gillan
Laser Protection Adviser to RQIA

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