The Regulation and Quality Improvement Authority

Inspection Report

17 April 2023

Ulster Independent Clinic

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

Tel No: 028 9066 1212

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Ulster Independent Clinic **Responsible Individual:** Ms Diane Graham	**Registered Manager:** Ms Diane Graham
Person in charge at the time of inspection: Ms Diane Graham	**Date manager registered:** 11 April 2007
Categories of care: Independent Hospital (IH) Acute Hospital (with overnight beds) AH Acute Hospital (Day Surgery) AH (DS) Private Doctor (PD) Prescribed Technologies: Endoscopy PT(E) Laser PT(L)	**Number of registered places:** 70
Brief description of the accommodation/how the service operates: The Ulster Independent Clinic (UIC) provides a wide range of surgical, medical and outpatient services for both adults and children. The hospital is registered to accommodate up to 70 patients as in-patients or day surgery cases. The hospital has five theatres along with recovery units; a dedicated endoscopy suite; a one stop breast care clinic; a limited chemotherapy service; an x-ray department and magnetic resonance imaging (MRI) scanning; a pathology laboratory; and a range of consulting rooms. The in-patient and day surgery accommodation comprises single en-suite rooms which are situated over two floors.	

2.0 Inspection summary

An unannounced inspection was undertaken to the Ulster Independent Clinic on 17 April 2023 and concluded on 11 May 2023 with feedback to the manager, Ms Diane Graham and members of the senior management and governance teams.

The hospital was inspected by a team comprised of care inspectors, RQIA medical lead, medical peer reviewers, a pharmacy inspector and an estates inspector.

This inspection focused on five key themes: governance and leadership; patient care records (medical); medicines management; estates and laser safety. The inspection also sought to assess progress with any areas for improvement (AFI) identified within the quality improvement plan (QIP) from the last care inspection to UIC on 1 November 2021.

Staff spoken with included managers, nursing and medical staff and allied health professionals (AHPs). Aspects of the management and oversight of governance across the organisation were reviewed.

It was established UIC have robust governance and oversight mechanisms to provide assurances relating to medical and clinical governance, management of incidents and care delivery. The hospital was provided with suggestions they may wish to consider in order to strengthen processes relating to practising privileges and peer review. There was evidence of effective communication systems to ensure staff and patients received key information. It was noted staffs' knowledge was good in relation to reporting and recording and managing incidents and complaints.

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

A number of quality improvement initiatives were in progress one of which included the introduction of an information leaflet for patients advising on pain management after hip or knee surgery. There are plans to introduce additional information technology (IT) systems to support the Quality and Education team. It is anticipated this which in turn should release clinical staff from inputting data to enable them to analysis information and complete validation audits and monitoring visits in wards and departments. Validation audits and monitoring visits provide assurance of a consistent approach to audits and ensures audits are reliable by evaluating audit evidence to determine whether specified criteria are met.

The one AFI identified during the previous inspection was reviewed and an assessment of achievement was recorded as met.

Two AFI's were identified one relating to laser safety and the second related to the oversight of the appraisal process of specialist nurses and evidencing clinical professional development for an allied health professional.

3.0 How we inspect

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

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

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

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

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

4.0 What people told us about the service

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

Five patients were spoken with during the inspection. The feedback from patients indicated that they were satisfied with their care and treatment. However, issues relating to the availability of parking were highlighted and these concerns were acknowledged by the manager. There was evidence this issue had also been discussed at a variety of meetings and actions identified by UIC to overcome the issue with parking were ongoing. Patient/relative postal questionnaires were distributed; no responses have been received.

Several interviews with medical staff and nursing staff from two wards, theatres and the Out Patients Department (OPD) were conducted. Staff provided positive feedback asserting that they felt well supported by management, had good lines of communication and that morale was good. Two partially completed electronic questionnaires were received by RQIA from staff. One highlighted issues relating to receiving feedback from their manager following work related discussions, and this information was shared with the manager who agreed to investigate and action accordingly.

5.0 The inspection

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

The last care inspection to UIC was undertaken on 1 November 2021 by a team of inspectors; one AFI was identified.

<table>
<tr><th colspan="3">Area for improvement from the last inspection on 1 November 2021</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and Department of Health (DoH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Regulation 15 (1)

Stated: First time</td><td>The Registered Person shall:

• Introduce malnutrition screening, to include the use of a malnutrition screening tool, in line with NICE Clinical Guidance CG32 and corresponding training for staff</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
It was confirmed malnutrition screening has been introduced which includes the use of the Malnutrition Universal Screening Tool (MUST). 85% of staff have received corresponding training with plans in place to ensure any outstanding training is completed.</td></tr>
</table>

5.2 Inspection findings

5.3 Governance and Leadership

5.3.1 Organisational and Clinical Governance

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

There was evidence that staff are recruited and employed in accordance with relevant employment legislation and best practice guidance; relevant information had been sought and retained. Induction programmes were in place for new staff. Staff told us that they felt supported by the management team. There are monitoring arrangements for mandatory training. Nursing staff confirmed that it is a requirement prior to taking up their position to have completed mandatory training. Review of recruitment files for specialist nursing staff employed through the hospital bank and an Allied Health professional (AHP) evidenced not all relevant documentation was present. The files did not include evidence of annual appraisal and continuing practice development for the AHP. There was evidence of up to date professional bodies registration. An AFI has been identified in relation to ensuring the hospital contribute to and retain evidence of annual appraisals and continuous practice development for all staff.

All staff spoken with were aware of their roles, responsibilities and accountability within the organisation. Staff said they would feel comfortable raising any concerns. Staff said that they were respected and valued and confirmed that they felt well supported by the manager and the senior management team.

There were systems in place to promote effective communication with all staff. There was evidence of daily staff briefs, staff meetings and information was disseminated to staff directly from managers and through learning boards. Staff confirmed they received feedback and learning via staff meetings, emails, minutes, managers, and via the Governance Matters News Letter.

Supervision arrangements were in place for nursing staff, and staff told us management are sourcing training in clinical supervision to increase the number and availability of staff trained as supervisors.

Service users are encouraged to submit feedback on their treatment and care. There was evidence of this feedback being shared with staff as a means of continually evaluating and driving service improvement.

A range of policies and procedures were accessible and evidenced. Policies and procedures examined were in date with a planned review date recorded and they were retained in a way that is easily accessible to all staff.

The hospital has a Clinical and Quality Governance Strategy 2022/2023 which outlines the strategic direction for the hospital. There is a defined clinical governance structure in place, it was noted two additional directors had been appointed, a Director of Governance and Risk and a Director of Clinical and Operational Services. The hospital's organisational chart had been updated to reflect these changes. There was evidence of regular meetings which included the Clinical Governance Committee (CGC), Medical Advisory Committee (MAC), and Practice Development Group, the minutes of these meetings were available for review. A monthly governance report is compiled by the Quality and Education (Q&E) team and presented to the Clinical Governance Committee meeting each month. These reports include information on staffing and staff management, medical staff practising privileges status, Nursing and Midwifery Council (NMC) registration status, mandatory training, staff absence, hospital risk register, audits, clinical incidents and complaints and patient experience. Action plans were created to address any deficits in performance. These action plans were specific, measurable, achievable, realistic, and time bound (SMART) and have led to a number of practice changes. Additionally, the Clinical Governance Committee in conjunction with the MAC meet on a monthly basis to identify appropriate topics for medical audit and oversee the implementation of these audits.

Risk management procedures were reviewed which provided assurance that risks identified with the hospital, treatment and services provided are identified, assessed and managed appropriately.

Systems were in place to ensure that the quality of services provided by the hospital is evaluated on an ongoing basis. Regular audits undertaken included; audits of venous thromboembolism (VTE) risk assessments, (the risk assessment is a tool used to assess a patients' risk of developing a blockage of a vein by a blood clot), infection prevention and control (IPC), surgical safety checklists, fluid balance charts, and prescription charts. A clear system was in place that addressed areas of non-compliance.

5.3.2 Complaints Management

The complaints procedure and whistleblowing policy were available and staff were knowledgeable in what actions they should take to manage a complaint. Examination of the complaints records confirmed that information recorded for complaints included nature/type of complaint, department involved, clinical speciality involved, risk rating, outcome and complainant satisfaction. The hospital subscribes to the services of the Independent Sector Complaints Adjudication Service (ISCAS). ISCAS provides independent adjudication on complaints if a patient is not satisfied with the outcome of a complaint made to an independent healthcare provider. There was evidence of shared learning and changes implemented following complaints analysis.

5.3.3 Notifiable Events/Incidents

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

A monthly summary of adverse clinical risks is presented as part of the governance report to the CGC. A summary of all adverse incidents along with learning from incidents are shared with staff.

There were effective arrangements 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. Systems were in place for staff to review alerts and confirm they have read them. The hospitals processes could be further strengthened by introducing to the audit of clinical incidents, a section to review all incidents in conjunction with The Independent Health Care Regulations (Northern Ireland) 2005**.** This will provide assurance any incidents that are notifiable to RQIA are reported.

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

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

5.3.4 Practising Privileges

Within independent health care establishments there is a responsibility on the management and medical assurance team to ensure the medical staff working there have the necessary and up to date skills and experience to practice, and there are a number of assurances doctors must provide to the MAC before the doctor is granted practising privileges.

The hospital's "Framework for Medical Governance Policy" contains the procedure that defines the process for application, granting, maintenance, suspension and withdrawal of practising privileges. The hospital's "Policy on Processing of Applications for Practising Privileges" outlines the process and the responsibilities of the MAC and CGC. This process could be further strengthened by developing (a) a flow chart which clearly describes the process for granting/renewal of practising privileges, identifying individuals responsible for each step in the process and (b) outlines the actions and agreed timeframes at each stage of the process if compliance is not achieved/information not submitted to support application and/or renewal.

There are systems in place to review practising privileges agreements in accordance with the relevant legislation. The practising privileges process allows for medical practitioners to make a self-declaration regarding their scope of practice, which UIC validate.

It was evident that hospital management maintained a system in relation to the oversight of arrangements relating to practising privileges.

Medical practitioners with practising privileges provide UIC with assurances they have completed mandatory training in their employing HSC Trust. However, UIC do not currently provide medical practitioners with a list of the mandatory training required to work in UIC. The hospital should provide this to the individual outlining the completion of the training listed is a condition of granting and maintain practising privileges. This mandatory training list has subsequently been shared with RQIA and compliance will be assessed during future inspections.

A number of personnel files relating to medical staff and surgical assistants were examined during the inspection and overall relevant documentation was present in relation to professional indemnity, insurance and General Medical Council (GMC) registration. The Minimum Care Standards for Independent Healthcare Establishments (2014) state that doctors with practising privileges are required to provide evidence of their annual appraisal in line with General Medical Council (GMC) requirements. Governance arrangements to ensure annual medical appraisals were taking place and sufficiently comprehensive were reviewed. The manager stated there were four outstanding medical appraisals and the hospital had engaged with each individual medical practitioner in order to receive evidence of completion. There was evidence the outstanding appraisals had been discussed with the MAC and these medical practitioners were working in a restricted capacity which was in line with their Health and Social Care (HSC) Trust duties. Arrangements are in place for sharing of relevant information relating to appraisal with HSC Trusts, although there was no evidence the hospital had engaged with the medical practitioners' Responsible Officer (RO) regarding the outstanding appraisal as identified as an action within minutes of a MAC meeting. This was discussed with the manager during the inspection and confirmation has been received that two medical appraisals remain outstanding and the relevant ROs have been contacted in relation to the these. The process for escalation should this occur in the future, could be further strengthened by developing a policy in relation to the requirement that medical practitioners need to provide UIC with evidence they have completed their annual appraisal, and outline the actions to be taken if this is not submitted within specified timeframes.

5.3.5 Quality Assurance

An essential part of assuring and improving care delivered through any service is the ability to quality assure clinical practices within the service. Quality assurance of clinical care may be undertaken through a number of mechanisms: clinical audit, peer review and monitoring of clinical outcomes.

The hospital has an agreed set of clinical quality indicators (Qis) and has systems in place to monitor these. The Q&E Department centrally collates quality indicator data which the CGC and MAC review regularly. A "Governance Matters" newsletter is issued to staff every two months and includes information on training updates, policy updates, clinical audits completed and adverse incidents and any associated learning. There was evidence of robust triangulation and analysis of the information. Staff told us there are plans to introduce additional information technology (IT) systems to support the Q&E Team which in turn should release clinical staff from inputting data and provide enhanced capacity to analyse information, conduct audits and complete monitoring visits to wards and departments.

UIC submit data to national clinical audits such as the Joint Registry, Cancer Registry and are progressing work in conjunction with the DOH in order to submit data to the Breast Registry. The hospital has contributed to the Private Healthcare Information Network (PHIN) for a number of years, in an effort to benchmark the safety and quality of their services against similar services across the UK. However, on 12 April 2023, UIC were informed by the Competitions and Markets Authority (CMA) of a breach of Article 21 of the Private Healthcare Market Investigation Order 2014 (the Order). Article 21 of the Order requires every operator of a private healthcare facility to supply PHIN with information about healthcare episodes it has carried out for patients treated at the facility. The data must be sufficiently detailed and complete to enable PHIN to publish information about the performance of the hospital, and consultants who work there to inform patient choice. UIC are working closely with PHIN to ensure it fully complies with the order despite significant compatibility challenges presented by different data systems and regulatory regimes across the UK and in the absence of a centralised province-wide digital data capture of patient information. Significant progress in relation to this matter has been made to date, with continued oversight by the CMA.

Peer review is the professional assessment of practice against standards of care, the organisation, healthcare processes and the quality of work with the objective of facilitating improvement. A peer is an individual practicing in the same profession and who has the expertise to evaluate the subject matter under review, identify problems and offer recommendations. Peer review can occur in a variety of ways such as through multidisciplinary meetings to facilitate peer discussion and challenge, peer review of cases where there have been incidents / complaints / concerns, and routine peer review of a sample of patient cases.

Within UIC peer review occurred whenever concerns or issues arose through clinical audit or directly following an incident. UIC have engaged the services of both internal and external peer reviewers for some specific cases; this was considered to represent good practice. However, in terms of routine peer review of every day practice there was no evidence that professional practice evaluation was occurring. There is potential risk associated with those individual medical practitioners, AHPs and specialist nurses working in isolation; for example, those working in OPD's. UIC may wish to develop, implement and assure a systematic approach to ongoing practice evaluation/ routine ongoing clinical peer review across its services, taking into account the specific risks associated with lone working.

In addition to peer review mechanisms, multidisciplinary team meetings, such as morbidity and mortality (M&M) meetings, enable healthcare professionals to discuss complex cases and to identify and learn from any discrepancies in management. Formal M&M meetings do not take place within UIC, although some clinicians have access to such meetings within HSC Trusts. RQIA would encourage UIC to consider establishing forums which provide an opportunity for a wider group of clinicians to meet outside the CGC and MAC meeting. This forum would provide a group of clinicians to meet to discuss cases, complications, complaints and could also facilitate mortality and morbidity discussions.

5.4 Patient Care Records (Medical)

Records were reviewed to assess if they were maintained in accordance with legislative requirements and best practice guidelines. The hospital is registered with the Information Commissioners office (ICO). The ICO upholds information rights in the public interest, promoting openness by public bodies and data privacy for individuals. Records required by legislation were retained and made available for inspection at all times.

A sample of patient care records were reviewed and confirmed that they included a contemporaneous note of each patients' medical history, medicine regime and all treatment provided.

There were some concerns relating to the legibility of clinical care records and the recording of General Medical Council (GMC) numbers alongside entries in line with GMC good practice advice. There was evidence of audit of patients' records which provided assurance that any issues identified as a result of audit are actioned appropriately.

There was an up to date policy in place for records retention schedule and records were held in a secure environment. Independent hospitals are not linked into the Electronic Care Records (ECR) system in the same way as HSC hospitals. Staff described issues that related to their inability to access ECR which impacts their ability to check clinical information in a timely manner, and the potential patient safety issues which could arise. RQIA have and will continue to engage with the relevant bodies to highlight the concerns.

5.5 Estates

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

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

The hospital's Authorised Engineer for the premises' specialised ventilation systems and medical gas pipeline services confirmed these systems are serviced and maintained in accordance with current best practice guidance. Review of documents relating to decontamination of surgical instruments within the hospital provided assurances that validation is undertaken in accordance with the current Health Technical Memoranda. Records and validation reports were available and reviewed at the time of the inspection.

A current Legionella Risk Assessment was in place and suitable control measures for the premises hot and cold water systems were being undertaken with appropriate records being maintained. It was established that a full chemical treatment of the premises' hot and cold water systems is undertaken annually. Regular bacteriological sampling of the hot and cold water systems is also regularly undertaken and appropriate action is taken when necessary.

The Fire Risk Assessment had been recently undertaken on 24 November 2022 by a suitably accredited fire risk assessor. The overall assessment of the risk assessment was assessed as 'tolerable' and the significant findings had been suitably addressed. Through discussion with staff it was confirmed suitable fire safety training was being delivered and staff demonstrated that they were aware of the action to be taken in the event of a fire.

Following a visual inspection of the premises it was established the overall environment including the entrance, reception, bedrooms, theatres, treatment rooms and consultation rooms were being maintained to a high standard of decoration.

5.6 Medicines Management

Safe systems were in place for the management of medicines within the hospital.

The pharmacists and pharmacy assistants work as part of the multi-disciplinary healthcare team and are responsible for the provision of safe, efficient, economical and timely pharmaceutical services throughout the hospital. The pharmacy assistants work under the direction and supervision of the pharmacists.

The pharmacists are responsible for ensuring the safe storage, handling, and disposal of all medicinal products at the hospital, including adherence to legislation regarding controlled drugs. This includes statutory three monthly reviews of the management of controlled drugs in each department and the provision of appropriate current stock for departments. The pharmacists provide drug information and advice to all departments and, on request, to individual medical consultants and patients. They have overview responsibility in relation to issues of patient safety regarding the procurement, storage and use of medicines. This includes action on appropriate and relevant medicine and medical devices alerts.

There were written policies and procedures for the management of medicines. Standard Operating Procedures (SOPs) that cover all aspects of the management of controlled drugs were in place.

It was evidenced that the management of medicines was undertaken by qualified, trained and competent staff and that systems were in place to review staff competency following any adverse drug event. The manager and healthcare staff spoken to advised that staff received an induction pack tailored to their specific area of work and that the completion of training was monitored.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Medicines were ordered by designated staff. Separate requisition/receipt records were in use for general medicines and controlled drugs.

Patients' own medicines brought into the hospital are assessed before use and where they are not used they are kept separate from other medicines and held in a safe place until discharge of the patient when they are returned to them or their representative. Pharmacy and nursing staff advised that patients were provided with information regarding any medicines prescribed within the hospital both during their stay and as an integral part of the discharge process.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. There were systems

in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Medicine refrigerators and the contents of emergency trolleys were checked at regular intervals.

Robust arrangements were in place for the storage, security, administration, disposal and recording of controlled drugs. Records confirmed that stock checks of controlled drugs were carried out twice daily. As a matter of good practice, some controlled drugs not subject to safe custody requirements were stored in the controlled drug cupboards and stock balances were reconciled at the end of each shift as an increased security measure.

Patient medicine kardexes were well maintained, including completion of the patient's weight, VTE risk and allergy status. In relation to medicines administration, the records indicated medicines were being administered as prescribed; and in cases where medicines had been omitted, the reason for this had been documented.

The regular review by the pharmacists of patients' medicine kardexes on the wards, on a daily basis from Monday to Friday had recently lapsed. The manager stated that she was aware of this matter and planned to ensure the practice is reintroduced.

Antimicrobial stewardship is the process in which antibiotics are prescribed, monitored and evaluated in an effort to preserve their future effectiveness and in line with evidence-based antimicrobial guidelines. This should improve and reduce the progression of antibiotic resistance and optimise patient outcomes. Organisations must ensure there are systems and process in place to ensure a standardised and consistent approach by staff to prescribing. Prescribing should be monitored and reviewed.

There were arrangements in place to audit various aspects of the management of medicines. In addition to the controlled drug audits, these audits included:

- Antimicrobial stewardship
- VTE risk assessment forms and prophylactic prescribing
- Adverse drug events

There were reporting systems in place for identifying, recording, reporting, analysing and learning from adverse drug events and near misses. Adverse drug events were reviewed and categorised by the Director of Governance and Risk, the Q&E team and pharmacists and were discussed, when necessary, at the senior clinical staff meetings. Where a controlled drug event occurred, a pharmacist held a reflective session with the staff involved. Learning from incidents is disseminated to staff through ward meetings, newsletter and electronic communications.

A hospital antimicrobial stewardship policy was in place. The policy described the prophylactic medications that may be prescribed by clinicians practising in the hospital. To provide assurance that the policy was being adhered to, antimicrobial prescribing audits were performed every three months. Any issues arising from the audits were followed-up by means of an action plan and the results were reported at senior clinical staff meetings.

5.7 Laser Safety

The Laser Protection Advisor (LPA) for RQIA reviewed the arrangements in respect of the safe use of the laser equipment at UIC and provided a report which has been appended to this report.

Review of laser services confirmed that laser and intense light source procedures are carried out by appropriately trained staff in accordance with best practice.

A list of clinical authorised users is maintained. It was noted the Register of Authorised Users and Laser Manual Signature Sheet was incomplete and not all staff who assist with laser use had signed they had read the laser manual.

The hospital appointed LPA confirmation certificate did not specify the duties of the LPA and had not been signed. Staff confirmed that the risk assessment undertaken by the hospital appointed LPA was reviewed yearly, on observation the current risk assessment was incomplete. The hospital should ensure that the certificate and risk assessment are updated and contain all the relevant information, in accordance with best practice and retained in the laser safety file.

On discussion with staff it was identified there is a staff member whom assists with LPS duties. However, they had not been appointed as a deputy LPS. The hospital should appoint a deputy LPS to ensure additional cover if the LPS is not available.

Laser safety training records for authorised operators and support staff were reviewed. The equipment training record for one of the authorised users was not available and there were gaps in training records for some staff who assist during laser procedures. The Laser Safety Core of Knowledge training certificates for the LPS and the staff member who assists the LPS were dated September 2017, it is good practice for staff to renew this training at least every five years. The hospital must ensure that training for laser staff is up to date and training records are maintained.

On review of the local rules which contain relevant information pertaining to the laser equipment being used it was noted the arrangements for the safe custody of the laser suite key did not accurately reflect the current practice. These should be reviewed to ensure they reflect local practice, or alternatively the arrangements could be documented in a separate policy. The eye protection used by the patient was not specified in the local rules. The hospital should consult their LPA on this matter and if the LPA is satisfied that the eye protection is suitable, then the details should be added to the local rules.

There are arrangements in place to service and maintain the laser equipment in line with the manufacturer's guidance.

An AFI has been identified in relation to the laser safety.

Laser Protection Report

9 May 2023

Site Details:
Ulster Independent Clinic
245 Stranmillis Road
Belfast
BT9 5JH

Laser Protection Adviser appointed by site:

Philip Loan, One Photon

Laser/IPL Equipment:

Make	Model	Class	Serial Number	Wavelength(s)
Cook Medical	Rhapsody H-30	4	LHT - 0563 - 0416	2100nm (Ho:YAG)

Introduction

A Laser Protection Adviser (LPA) inspection of Ulster Independent Clinic was performed on 19 April 2023. This report summarises the main aspects of the inspection and document review where improvements may be required. The findings are based on the requirements of the Minimum Care Standards for Independent Healthcare Establishments published July 2014 by the Department of Health, Social Services and Public Safety (DHSSPSNI) and other relevant legislation, guidance notes and European Standards.

The LPA inspection included a review of:

- Protective eyewear
- Environment/signage
- Training records and user authorisation
- Laser device markings
- Maintenance Records
- Treatment protocols
- Risk assessments
- Local Rules
- Appointment of duty holders (LPS/LPA)

Comments / Recommendations:

1. **LPA appointment confirmation:** Although a certified LPA had been appointed, the appointment confirmation certificate supplied by the LPA had not been signed by the clinic. In addition, this certificate did not specify the duties of the certified LPA.

The clinic should sign the LPA appointment confirmation certificate in the laser safety file. If the clinic has written confirmation of the duties of the LPA, a copy of the duties should be added to the laser safety file. Alternatively, the duties agreed with the LPA should be documented.

2. Deputy Laser Protection Supervisor: The role of deputy LPS was discussed with the LPS and they indicated there is a staff member who assists with the LPS duties, however they had not been appointed as a deputy LPS. The clinic should appoint a Deputy LPS to ensure cover is available if the LPS is away.

3. Training: The following points relating to the training & training records were discussed with the clinic on the day of inspection for remedial action:

a) On the day of the inspection, there was no equipment training record available for one of the authorised laser users.
b) The Laser Safety Core of Knowledge training certificates for the Laser Protection Supervisor (LPS) and the staff member who assists the LPS were dated Sept 17. It is good practice for staff to periodically re-attend laser safety training e.g. at least every 5 years.
c) Laser equipment training - some staff assisting during laser procedures had not completed laser equipment training.
d) Laser safety training - although most assisting staff had completed equipment training, there were no training records available for these staff demonstrating they had also completed laser safety training. All assisting staff should have up to date training in laser safety.
e) The clinic should ensure that training for laser staff is up to date and training records are maintained.

4. Register of Authorised Users and Laser Manual Signature sheet: The following points relating to the Register of Authorised Users and Laser Manual Signature sheet were discussed with the clinic on the day of inspection for remedial action:

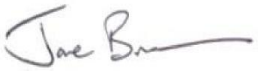
a) The authorised laser users have not signed to indicate that they accept and understand the local rules and medical treatment protocols.
b) Only some of the assisting staff had signed they have read the laser manual.
c) The clinic should ensure that once staff have read the laser manual, they sign the relevant signature sheet.

5. Risk Assessment: Although discussions with the LPS confirmed that the risk assessment undertaken by the LPA was reviewed yearly, the risk assessment did not include details on who approved the assessment, when it was completed, or review date. In accordance with best practice, the clinic should ensure that the risk assessment is updated with these details. Written arrangements for safe custody of key: The written arrangements in the local rules for the safe custody of the key were somewhat generic. These should be reviewed to ensure they reflect local practice, or alternatively the arrangements could be documented in a separate policy.

6. Patient Eye Protection: The eye protection used by the clinic for the patient was not specified in the local rules. The clinic should consult their LPA on this matter and if the LPA is satisfied that the eye protection is suitable, then the details should be added to the local rules.

7. LPA Report: Point 13 of the LPA report had not been actioned by the clinic. The clinic should file the LPA certificate provided in the laser safety file.

The clinic should inform RQIA when the above points have been addressed.



Mrs Jane Brown
Laser Protection Adviser to RQIA

5.8 Equality

The arrangements in place in relation to the equality of opportunity for patients and staff was discussed with the manager. All staff have completed equality awareness training. Staff are aware of equality legislation and how to recognise and respond to the diverse needs of patients and others.

Discussion with the manager and review of information evidenced that the equality data collected was managed in line with best practice and the manager confirmed equality data is submitted annually to the Equality Commission for Northern Ireland.

6.0 Quality Improvement Plan/Areas for Improvement

Two areas for improvement have been identified where action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005; and Department of Health (DoH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

	Regulations	Standards
Total number of Areas for Improvement	0	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Diane Graham, Responsible Individual/Registered Manager and members of the senior management team, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and Department of Health (DoH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).	
Area for improvement 1 **Ref:** Standard 13 Criteria 13.9 **Stated:** First time **To be completed by:** 1 July 2023	The registered manager must ensure: • All staff including specialist nursing and AHPs have a recorded annual appraisal to review their performance against their job description, agree personal development plans and maintain evidence of CPD relevant to their role. Ref: 5.3.1
	Response by registered person detailing the actions taken: Departmental Heads have been advised to include all bank staff in the appraisal process which also includes a review of CPD

Area for improvement 2 **Ref:** Standard 48 Criteria 48.2 Criteria 48.13 Criteria 48.17 Criteria 48.21 **Stated:** First time **To be completed by:** 1 July 2023	With respect to the use of lasers the registered manager must ensure: • A register of authorised users is maintained and kept up to date; • All support staff have up to date awareness training in laser and intense light source safety; • Protective eyewear is available for the patient and authorised operator in accordance with the local rules; and • A laser safety file is in place which contains all of the relevant information in relation to laser or intense light equipment. Ref: 5.7
	Response by registered person detailing the actions taken: The register of authorised users has been reviewed and is up to date. Training for support staff in laser safety awareness has been undertaken on 20 and 27 June 2023.Protective eyewear is always available for patients and authorised operators - this has now been detailed in the local rules. The laser safety file has been reviewed and updated. A deputy LPA has been identified and training is being arranged.

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

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