# Announced Care Inspection Report
# 20-21 September 2016

# Ulster Independent Clinic

**Type of service: Independent Hospital – Surgical Services**
**Address: 245 Stranmillis Road, Belfast BT9 5JH**
**Tel no: 028 90 661212**
**Inspectors: Winnie Maguire & Carmel McKeegan**
**RQIA's Medical Physics Advisor: Dr Ian Gillan**

## 1.0 Summary

An announced inspection of Ulster Independent Clinic took place on 20 and 21 September 2016 from 9.50 to 16.10 and 9.50 to 16.00 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.

The inspection sought to determine if the independent hospital – surgical service was delivering safe, effective and compassionate care and if the service was well led.

**Is care safe?**

Observations made, review of documentation and discussion with Ms Diane Graham, registered provider/manager, Mrs Wendy Cathcart, the quality and education sister and staff demonstrated that systems and processes were in place to ensure that care to patients was safe and avoids and prevents harm. Areas reviewed included staffing, recruitment and selection, surgical services, laser safety, safeguarding, resuscitation and management of medical emergencies, infection prevention control and decontamination, and the general environment. A recommendation was made in relation to core of knowledge update training for the authorised users of the lasers operated in theatre. The hospital is undergoing two renovation projects, one is in relation to the building of a new outpatients department and endoscopy suite; the other relates to the upgrading of an inpatient area on level two. A variation of registration application has been submitted for the outpatient department and endoscopy suite and it was recommended a further variation of registration application is submitted for the renovation work on level two.

**Is care effective?**

Observations made, review of documentation and discussion with Ms Graham, Mrs Cathcart and staff demonstrated that systems and processes were in place to ensure that care provided in the establishment was effective. Areas reviewed included clinical records, the care pathway, patient information and decision making and discharge planning. No requirements or recommendations have been made.

**Is care compassionate?**

Observations made, review of documentation and discussion with Ms Graham, Mrs Cathcart and staff demonstrated that arrangements are in place to promote patients' dignity, respect and involvement in decision making. Areas reviewed included dignity, respect and rights, informed consent, breaking bad news and patient consultation. No requirements or recommendations have been made.

**Is the service well led?**

Information gathered during the inspection evidenced that there was effective leadership and governance arrangements in place which creates a culture focused on the needs of patients in order to deliver safe, effective and compassionate care. Areas reviewed included organisational and staff working arrangements, clinical governance systems, the arrangements for policy and risk assessment reviews, the arrangements for dealing with complaints, incidents

and alerts, insurance arrangements, the arrangements for managing practising privileges and the registered person's understanding of their role and responsibility in accordance with legislation. No requirements or recommendations have been made.

This inspection was underpinned by 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).

## 1.1 Inspection outcome

| | Requirements | Recommendations |
|---|---|---|
| **Total number of requirements and recommendations made at this inspection** | 0 | 2 |

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Diane Graham, registered provider/manager and Mrs Wendy Cathcart, 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.

## 1.2 Actions/enforcement taken following the most recent care inspection

There were no further actions required to be taken following the most recent inspection.

## 2.0 Service details

| | |
|---|---|
| **Registered organisation/registered person:**<br>Ulster Independent Clinic<br>Ms Diane Graham | **Registered manager:**<br>Ms Diane Graham |
| **Person in charge of the establishment at the time of inspection:**<br>Ms Diane Graham | **Date manager registered:**<br>11 April 2007 |
| **Categories of care:**<br>Acute hospitals (with overnight beds)AH<br>Acute Hospital (Day Surgery ) AH(DS)<br>Prescribed Technologies, Endoscopy PT(E)<br>Prescribed Technologies, Laser PT(L) | **Number of registered places:**<br>70 |

**Laser equipment (In use in theatre five)**

**Manufacturer**: Cook Medical

**Model**: Ho.Yag Odyssey 30

**Serial Number**: 29020-XWQZV

**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

A class 3B laser was also noted to be in use, operated by qualified physiotherapists in the physiotherapy department. This laser is exempt from regulation however a short review was undertaken and advice given. Following inspection Ms Graham confirmed that the laser had been decommissioned with immediate effect.

## 3.0 Methods/processes

Questionnaires were provided to patients and staff prior to the inspection by the hospital on behalf of the RQIA. Prior to inspection we analysed the following records: notification of reportable incidents, duty calls, complaints declaration and returned completed patient and staff questionnaires.

During the inspection the inspectors met with Ms Diane Graham, registered provider/manager, Mrs Wendy Cathcart, quality and education sister, two senior theatre sisters, a recovery ward sister, a ward sister, two inpatient ward nurses, three outpatient nurses, a superintendent radiographer, a superintendent physiotherapist, two physiotherapists, a biomedical scientist, a member of the human resource's team and four patients. A tour of the premises was also undertaken.

Records were 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

## 4.0 The inspection

## 4.1 Review of requirements and recommendations from the most recent inspection dated 17 August 2016

The most recent inspection of the establishment was an announced premises inspection. The completed QIP has been issued and will be approved by the estates inspector. This QIP will be validated by the estates inspector at the next estates inspection.

## 4.2 Review of requirements and recommendations from the last care inspection dated 20 October 2015

No requirements or recommendation were made as a result of the last care inspection

## 4.3 Is care safe?

**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 commence employment.

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 three 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 confirmed that a robust system was in place to review the professional indemnity status of all staff who require individual indemnity cover. Review of medical practitioner's details and discussion with Ms Graham confirmed robust arrangements are in place to ensure medical practitioners have appropriate professional indemnity insurance and receive the required annual appraisals.

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

Two 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

It was confirmed that each medical practitioner has an appointed responsible officer.

**Recruitment and selection**

It was confirmed that staff have been recruited since the previous inspection. A review of three personnel files for some of 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 which are in accordance with good practice guidelines and national standards.

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

The scheduling of patients for surgical procedures is co-ordinated by the theatre manager or her deputy, 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, and
- discuss options for post-operative pain relief

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

It was confirmed 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 the nurse in charge of each theatre. Ms Graham and theatre staff confirmed a number of additional senior nursing posts had been created to consolidate these arrangements.

Discussion with staff confirmed 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 safety checklist based on the World Health Organisation (WHO) model is used in the hospital. Completion of the surgical safety checklists is audited as part of the hospitals comprehensive clinical governance systems. Review of the audits confirmed that a high compliance rate is achieved. Staff confirmed surgical pause and completion of the surgical safety checklist is embedded in practice.

It was 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 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.

Staff confirmed arrangements for intra-operative fluid management and the latest version of an intra-operative fluid management record was reviewed. The management and prevention of hypothermia in theatre was discussed and staff demonstrated effective systems are in place, which are subject to regular audit.

As most theatres were in use during the inspection, it was only possible to review theatre four. It was noted to be clean, tidy and with a wide range of theatre equipment in place. The theatre set up checklist was reviewed and found to be appropriate.

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

**Laser Safety**

A laser safety file is in place which contains all of the relevant information in relation to laser equipment. It was suggested to declutter the laser safety file by retaining current information and archiving information which is not current.

There was written confirmation of the appointment and duties of a certified laser protection advisor (LPA) which is reviewed on an annual basis.

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.

Up to date local rules are in place which have been developed by the LPA. The local rules contained the relevant information pertaining to the laser equipment being used.

The establishment's LPA completed a risk assessment of the laser in use in theatre five in March 2016 and all recommendations made by the LPA have been addressed.

A list of clinical and non-clinical authorised users is maintained and authorised users have signed to state that they have read and understood the local rules and medical treatment protocols.

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 user to deputise for the LPS in their absence, who is suitably skilled to fulfil the role.

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.
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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.

The hospital had a 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

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.

A review of core of knowledge training for the clinical authorised users, six consultant urologists, found that it has been over five years since they have undertaken this training. A recommendation was made to invite the clinical authorised users to undertake a core of knowledge update.

**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.

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.

**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

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 hospital has a designated IPC lead nurse.

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 have 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.

The hospital was found to be clean, tidy and well maintained. Ms Graham confirmed that the cloth covered chairs in the waiting rooms are to be recovered with a wipeable material in line with IPC best practice.

A review of infection prevention and control arrangements indicated that very good infection control practices are embedded in the hospital

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 two renovation projects, one is in relation to the building of a new outpatients department and endoscopy suite; the other relates to the upgrading of an inpatient area on level two. A variation of registration application has been submitted for the outpatient department and endoscopy suite and it was recommended a further variation of registration application is submitted for the renovation work on level two.

The outpatient department has been relocated to a temporary structure which has been seamlessly installed in the hospital. Review of this area found it to be of a high quality and suitable to meet the needs of outpatients.

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 staff demonstrated that arrangements are in place for maintaining the environment.

A RQIA estates inspection was conducted in August 2016; maintenance arrangements and associated documentation were examined as part of the inspection.

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

Three patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm. Patients spoken with during inspection concurred with this. The following comment was provided in a submitted patient questionnaire:

- “I felt nothing else mattered to staff but my welfare, physical and emotional.”

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

## Areas for improvement

Clinical authorised users should be invited to undertake a core of knowledge update.

A variation of registration application should be submitted for the renovation work on level two.

| **Number of requirements** | 0 | **Number of recommendations** | 2 |
|---|---|---|---|

## 4.4 Is care effective?

### 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, intra-operative and post-operative care which clearly outlined the patient pathway and included the following:

- patient personal information
- holistic assessments
- pre-operative care plans
- pre-operative checks
- signed consent forms
- surgical safety checklist
- 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 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 were signed by the consultant surgeon and the patient.

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

- "Excellent in every way."
- "Staff couldn't be nicer; everything was explained, very reassuring."
- "Felt very safe."
- "Staff very attentive; I was ill overnight and they were wonderful."

### 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 sister 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 her and explained the discharge process and referrals to other services. The patient stated she was very reassured by the consultation and felt fully involved in her 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.

**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. The following comment was provided:

- "I could not have imagined being cared for anywhere else in the province – my care was of the very highest standard imaginable. Very thankful to all staff."

All submitted staff questionnaire responses indicated that they felt that patients get the right care, at the right time and with the best outcome or them. Staff spoken with during the inspection concurred with this. No comments were included in submitted staff questionnaire responses.

**Areas for improvement**

No areas for improvement were identified during the inspection.

| **Number of requirements** | 0 | **Number of recommendations** | 0 |
|---|---|---|---|

## 4.5 Is care compassionate?

### 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. Outpatient's services are provided in individual consultation rooms.

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 four patients, staff and review of four 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/or their relatives/representatives with compassion, dignity and respect. Discussion with patients confirmed this. Comments received from patients included:

- "Staff were so kind and patient with me"
- "Wonderful caring staff"
- "I was treated with the greatest respect"

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 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 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 inspector spoke with staff who confirmed that bad news is delivered to patients and/or their representatives by senior clinicians who have experience in communication skills and act in accordance with the hospital's policy and procedure.

Where bad news is shared with others, staff confirmed that consent must be obtained from the patient and 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.

It was confirmed 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:

- "I couldn't ask for better care and attention during my stay in the clinic."
- "Everyone has been very helpful and kind, I could not have wished for better care."
- "Excellent stay. Nursing staff excellent very helpful and caring."
- "Can't say enough good things about the staff."
- My thanks to all who took such good care of me."
- "WiFi slow"

The following comment was noted in a child's completed questionnaire:

- "The best thing about being in the clinic – the en-suite, TV, good food and the friendliness of doctors and nurses."

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

Discussion with Ms Graham and the quality and education sister confirmed that comments received from patients and/or their representatives are reviewed by senior management within the hospital 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. The following comment was provided:

- ‘‘All of the staff were so very, very kind, I felt cherished in the confines of my room – safe and cared for. It was with a little reluctance I returned to the outside world.”

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. Staff spoken with during the inspection concurred with this

**Areas for improvement**

No areas for improvement were identified during the inspection.

| Number of requirements | 0 | Number of recommendations | 0 |
|---|---|---|---|

## 4.6 Is the service well led?

**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 for 2015/16 is in place. A range of committees support 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.

Clinical quality indicators were reported on in 2015 and a comparison made with results in 2010, which demonstrated improvement.

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, Mrs Cathcart 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

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.

Two 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 who 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 patient and child guide were noted to be under review and Ms Graham confirmed an external communications company had been commissioned to provide draft guides.

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 managed. The following comment was provided:

- "I have loved the fact that all of the staff I talked to loved their job; loved their colleagues; spoke about how supportive everyone was to each other. It was also so reassuring how staff spoke of the Drs/consultants with the highest regard and admiration, with genuine respect."

All submitted staff questionnaire responses indicated that they felt that the service is well led. Staff spoken with during the inspection concurred with this. The following comment was provided:

- "Patients are well cared for."

**Areas for improvement**

No areas for improvement were identified during the inspection.

| | | | |
|---|---|---|---|
| **Number of requirements** | 0 | **Number of recommendations** | 0 |

## 5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Diane Graham, registered provider/manager and Mrs 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 failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

## 5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on 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.

## 5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The DHSSPS Minimum Care Standards for Independent Healthcare Establishments(July 2014). They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

## 5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

## Quality Improvement Plan

| Recommendations | |
|---|---|
| **Recommendation 1**<br><br>**Ref**: Standard 48.12<br><br>**Stated:** First time<br><br>**To be completed by:**<br>21 December 2016 | Clinical authorised users of the laser should be invited to undertake a core of knowledge update. |
| | **Response by registered provider detailing the actions taken:**<br>Advice has been sought from the Clinic's Laser Protection Adviser who has forwarded details of an on-line course. Clinical authorised users will now be informed and asked to complete same. |
| **Recommendation 2**<br><br>**Ref**: Standard 22.2<br><br>**Stated:** First time<br><br>**To be completed by:**<br>21 October 2016 | A variation of registration application should be submitted for the renovation work on level two. |
| | **Response by registered provider detailing the actions taken:**<br>This has now been submitted. |

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