The Regulation and Quality Improvement Authority

Inspection Report

13 December 2021

Fitzwilliam Clinic

Type of Service: Independent Hospital (IH)
70-72 Lisburn Road
Belfast
BT9 6AF

Tel No: 028 9032 3888

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/The Independent Health Care Regulations (Northern Ireland) 2005 and Minimum Care Standards for Independent Healthcare Establishments (July 2014)

1.0 Service information

Organisation/Registered Provider: Fitzwilliam Partnership **Responsible Individuals:** Mr James Small Mr Stephen Sinclair Mr Andrew Kennedy	**Registered Manager:** Ms Denise Shields.
Person in charge at the time of inspection: Ms Denise Shields	**Date manager registered:** 12 November 2021
Categories of care: (IH) Independent Hospital AH(DS) - Acute Hospital (Day Surgery) PD - Private Doctor	
Brief description of the accommodation/how the service operates: Fitzwilliam Clinic is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital (IH) and provides a wide range of surgical, cosmetic and outpatient services and treatments for day surgery adult patients. There are no overnight beds provided by this hospital.	

2.0 Inspection summary

An unannounced inspection was undertaken to Fitzwilliam Clinic on Monday 13 December 2021 and concluded on 5 January 2022 with feedback to the Registered Manager (RM), Ms Denise Shields. The inspection team was made up of care inspectors, a medical practitioner and an estates inspector who provided remote support.

The inspection focused on eight key themes: governance and leadership; patient care records; surgical services/theatre; safeguarding; staffing; environment and infection prevention and control (IPC); and estates.

The inspection team met with a range of staff, including the manager, nursing and medical staff, and administrative staff. The management and oversight of governance across the organisation and aspects of frontline care and practices, was reviewed.

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of incidents and alerts and the arrangements for managing practicing privileges for medical practitioners. There was evidence of good communication systems to ensure that important information is received by staff; and there was confirmation that patients were treated with compassion, dignity and respect.

A number of practical measures for improvement were brought to the attention of staff and the RM during the inspection and during feedback.

Three areas for improvement (AFI) were identified during the inspection; one relating to suitable fire safety training for medical staff; one relating to the audit process and one in relation to the monitoring and oversight of the domestic store.

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

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

Inspectors assessed staff practices and examined records in relation to each of the areas inspected and met with the RM, members of the multidisciplinary team, and the senior management and governance team.

Experiences and views were gathered from staff and patients.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

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 progress. Staff and patients were invited to complete an electronic questionnaire during the inspection.

Two patient questionnaires were received by RQIA during the inspection. The feedback from patients indicated that they were satisfied with their care and treatment.

A number of staff interviews took place with medical, nursing and administrative staff. Staff told us they receive good support from the RM and the clinical sister and that they work in a supportive team. They felt listened to and were able to raise any concerns they may have. They reported challenges as a result of the COVID-19 pandemic including an increasing busy working environment and challenges with staff recruitment similar to all sectors across health and social care. Staff described the care within the hospital as compassionate and identified that patient safety was paramount.

A number of staff electronic questionnaires were completed which indicated a high level of satisfaction that patient care delivery was safe and effective and the service was well led.

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 inspection to Fitzwilliam Clinic was undertaken on 19 March 2021 by two care inspectors. No areas for improvement were identified during this inspection.

5.2 Inspection findings

5.3 Governance and Leadership

5.3.1 Clinical and Organisational Governance

There were clear operational structures and accountability arrangements in place. These arrangements were demonstrated by the holding of clinical and organisational governance meetings through which assurance was provided to the Responsible Individual. There is a designated individual with overall responsibility for the day to day management of the hospital. Staff were able to describe their role and responsibilities and confirmed that there were good working relationships with managers, who were responsive to any suggestions or concerns raised. Staff also spoke positively of the appointment of a new clinical nurse lead for the hospital.

Minutes of meetings were reviewed which confirmed that the Medical Advisory Committee (MAC) meets quarterly and arrangements are in place for extraordinary meetings, where necessary. Minutes of these meetings confirmed that all relevant agenda items were covered at these meetings.

Documents reviewed during the inspection described a wide range of activities including: monitoring of customer satisfaction; incident and trend analysis; and the outcomes of quality key performance indicator (KPI) audits such as hand hygiene practices, the management of invasive devices, sharps and medicines. These audits are used to assess performance against agreed standards as part of a rolling audit programme.

The documentation confirmed a high level of compliance by staff. Mechanisms were in place to ensure audit results are reviewed during the MAC meetings.

Improvement was identified in relation to the robustness of the audit process at the hospital, particularly around medicine and environment audits and the development of action plans underpinned by specific, measurable, achievable, realistic and timely (SMART) goals. Internal auditing for medicines (controlled drugs) was not always undertaken by two nurses or signed off by the registered manager in accordance with the hospitals' auditing process. Areas for improvement emerging from internal medicine audits did not always confirm that an identified action had been addressed and/or any learning shared with staff.

There was no evidence provided to confirm that an environmental audit of clinical areas was undertaken at the hospital. Routine monitoring and auditing of the cleanliness standards provides assurance that the hospital is meeting and maintaining a safe environment, and where this is deficient, should detail any areas for improvement.

In line with Standard nine of the Minimum Care Standards for Independent Healthcare Establishments (2014) an AFI will be made in relation to the robustness of the audit process to confirm that working practices are systematically audited to ensure they are consistent with legislation, best practise guidance and the hospital's documented policies and procedures; and that remedial action is taken when necessary. The use of independent validation audits would provide additional mechanism of assurance of the auditing process at the hospital. This was discussed with the RM who agreed to consider.

Policies and procedures were reviewed and confirmed that overall these were in date and accessible to all staff. We identified that one policy required updating and a small number of policies required a review date and/or version control applied, this was highlighted during our inspection and action was taken at the time to address.

Documentation was reviewed which confirmed that visits by the registered provider were undertaken every six months in line with Regulation 26, of the Independent Health Care Regulations (Northern Ireland) 2005.

The RQIA registration certificate and insurance certificate were displayed and up to date, and registration with Information Commissioners Office (ICO) was also in date.

Review of documentation confirmed that there were good governance systems in place regarding medical and nursing professional bodies' registration.

5.3.2 Practicing Privileges

The hospital has a policy and procedure in place, which outlines the arrangements for application, granting, maintenance, suspension and withdrawal of practicing privileges**.** There are systems in place to review practising privileges every two years. The inspection team found that hospital management maintained a robust oversight of arrangements relating to practicing privileges. A sample of personnel files of consultants operating during the course of the inspection were reviewed, and found that all relevant documentation was present in relation to professional indemnity, insurance and medical appraisals which were paused during the pandemic, but have since recommenced. Personnel files for three doctors in training were examined and confirmed robust oversight with practising privileges in place.

Medical staff received mandatory training through their substantive posts within Trusts; however, mandatory training bespoke to the hospital such as fire safety training should also be undertaken by medical staff. This was highlighted to the RM during the inspection who agreed to follow this up. An area for improvement has been made in respect of fire safety training for medical staff.

5.3.3 Communication

There are systems in place to promote effective communication with all staff. There was evidence of regular staff meetings with reception staff, and a joint meeting held with all staff in the hospital. Nursing staff told us that their staff meetings have been more consistent since the new clinical nurse lead has taken up post. Additionally, daily staff briefs are held and information is disseminated to staff directly from managers and by email.

Staff informed us that there were good working relationships between staff of all grades and they confirmed that they would have no hesitation in approaching one of the senior partners for guidance/support if their manager was not available.

5.3.4 Complaints Management

The hospital has a complaints policy and procedure in accordance with the relevant legislation and Department of Health guidance on complaints handling, which is available to patients and their representatives. There are clear arrangements in place for the management of complaints from patients. A review of complaints records confirmed that all details of communications with complainants, results of any investigation, the outcome and any action taken were documented. The hospital sought the views of patients and/or their representatives on a formal basis as an integral part of the service they deliver.

5.3.5 Notifiable Events/Incidents

A system is in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies as appropriate. This ensures adverse incidents, risks and complaints are minimised by effective identification, prioritisation, treatment and management. 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 are in place for staff to review alerts and confirm they have read them.

A review of the overarching corporate risk register confirmed that risks were documented, collated and tracked, and provided assurance about the effective identification and management of risk. Risks were scored according to likelihood and potential consequence to the hospital and services provided. Individuals were identified who were responsible for managing the risk and taking further actions. A summary of any adverse clinical risks were presented at the MAC meetings and corrective action was recorded.

It was noted that staff routinely manage the risks associated with the change in floor gradient leading to the theatre although this was not identified as a risk on the current risk register. This was highlighted to the RM who agreed to update the risk register to reflect this.

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

5.4 Patient Care Records (medical and nursing)

The hospital is registered with the ICO. Records required by legislation were retained and made available for inspection at all times.

A sample of records pertaining to patients were examined and found to be completed correctly. The records included comprehensive assessment of patient needs identified on admission and appropriate risk assessments, for example, venous thromboembolism (VTE). Care plans demonstrated ongoing assessment and evaluation of patient care and documented evidence that the patient and/or family have been involved in agreeing the plan of care.

There was an up to date policy in place for records retention schedule. Records were held in a secure environment.

5.5 Surgical Services/Theatres

A review of the arrangements for the provision of surgery confirmed that the hospital was operating under their statement of purpose and categories of care. This included arrangements in place for monitoring surgical assistants to confirm that they have been granted the appropriate practicing privileges. There were links with Trust hospitals for equipment and also decontamination services. Staff were compliant with best practice guidance for example the World Health Organisation (WHO) surgical checklist and surgical pause.

A wide range of comprehensive policies and procedures are in place to ensure that safe and effective care was provided to patients in accordance with good practice guidelines and national standards.

Review of the patient care records and discussion with staff confirmed the consultant performing the procedure meets with the patient prior to the procedure to discuss the procedure and obtain informed consent. Discharge criteria was in place to check the patient's condition and suitability to transfer from recovery to the waiting area if necessary or to home.

An identified member of nursing staff, with relevant experience is in charge during all procedures.

A review of the surgical register maintained for all surgical procedures undertaken in the hospital was found to contain all of the information required by legislation.

The theatre lists took into account the individual requirements of the patient, the type of procedure to be performed, availability of equipment, staffing levels required, associated risks and the level of sedation used.

An emergency trolley was located in the recovery area and checked daily by staff. Controlled drugs were held in an appropriate controlled drugs cupboard, and any other medicines were stored within locked cupboards. Stock control was in place. A drugs fridge was in use and daily temperature checks were carried out. Staff could describe the process for reporting medicine incidents.

Assurance was sought that an information sharing agreement existed between the hospital and NHS Digital with appropriate control measures in place to manage patient data on the Breast and Cosmetic Implant Registry (BCIR). The RM confirmed that this was in place.

5.6 Safeguarding

Arrangements for safeguarding of children and adults were reviewed. Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm, in line with the regional 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015); Adult Safeguarding Operational Procedures (2016); and 'Co-operating to Safeguard Children and Young People in Northern Ireland' (August 2017). Policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or a child.

It was confirmed that no procedures were carried out on children in the hospital.

Review of records demonstrated that all staff in the hospital had received training in safeguarding children and adults as outlined in the Minimum Care Standards for Independent Healthcare Establishments (July 2014). It was confirmed that the safeguarding lead has completed formal training in safeguarding adults in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (Revised 2016).

Staff were knowledgeable in the actions to be taken should a safeguarding incident be identified.

5.7 Staffing (recruitment and selection, training, supervision and appraisal)

Staff were recruited and employed in accordance with relevant employment legislation and best practice guidance. A random sample of staff personnel files were reviewed, inclusive of newly recruited staff, which confirmed that the information required by legislation was obtained and retained in the files.

Procedures are in place for staff supervision and appraisal in line with the hospital's policies. All staff had received clinical supervision and the majority of staff appraisals were completed. It was noted that plans were in place for any outstanding appraisals to be completed.

Induction programmes are in place for new staff. Systems are in place for recording and monitoring staff training and personal development. Mandatory training for all staff was up to date. It was noted that staff had completed First Aid training which included basic life support (BLS) and managing a medical emergency, although this was not evident on the training certificate. This was discussed the RM who agreed to review.

All staff should receive IPC mandatory training commensurate to their role. Secretarial staff do not routinely receive IPC training as part of their mandatory training requirements. This was discussed with the RM who agreed to review.

There was good governance around medical and nursing professional bodies' registration.

A review of documentation evidenced that doctors who deliver services in the clinic provide evidence of 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; and
- ongoing annual appraisal by a trained medical appraiser.

5.8 Environment/Infection Prevention and Control

Overall the environment and equipment were in a good state of repair, with a high standard of cleaning throughout the hospital. The general environment, consultation rooms, and theatre were clean and clutter free. COVID safe measures were in place and the waiting area adjusted accordingly to ensure social distancing. Hand sanitiser was available at all key points of care in the hospital, and hand hygiene practices observed were good. All staff working in the clinical area were compliant with current personal protective equipment (PPE) guidance.

There were clear lines of accountability regarding infection control, and access to an IPC advisor and microbiologist is available if required. An IPC link nurse is also available at the hospital to provide support and guidance to staff.

Environmental cleaning at the hospital was privately sourced and the cleaning service provided and maintained an excellent standard of cleaning in clinical areas. However, during the inspection it was observed that the domestic store was cluttered and cleaning equipment was not cleaned or appropriately stored after use. The RM was informed of the findings during the inspection and at feedback, and assurance was provided that urgent action would be taken to rectify and monitor the situation.

It was confirmed that cleaning staff have received formal training in IPC, Control of Substances Hazardous to Health (COSHH) and Health and Safety in line with the Independent Healthcare Regulations (NI) 2005.

An AFI was made in respect of the oversight and management of the domestic store and equipment used for cleaning to ensure there is a managed environment that minimises the risk of infection for patients and clients, visitors and staff.

A number of practical areas for action were identified during the inspection, including the use of a spray bottle containing chlorine disinfectant and the safe storage of alcohol hand sanitiser, which were promptly addressed.

5.9 Estates

The Estates section of the inspection was completed remotely. The management team of the hospital were provided with a checklist of estates related items to submit to the estates inspector for review. This included certification relating to the maintenance and upkeep of the building and engineering services as well as relevant risk assessments.

All requested building services validation/assurance reports and certificates were submitted for Estates Inspector review, and were found to be compliant with the relevant Health Technical Memoranda (HTM) guidance.

Maintenance activities were completed by a range of specialist contractors/competent persons.

The fire risk assessment (FRA) review was completed by a competent fire risk assessor on 9 November 2021. The FRA review was evaluated as `tolerable`, and the recommended review date was listed as November 2022.

The Authorising Engineer (AE) audit report for the engineering services was completed on 14 July 2021. The AE audit report contained an evaluation of the following engineering services:

- Medical Gas Pipeline System, HTM 02-01;
- Water hygiene/legionella safety, HTM 04-01,
- Electrical LV, HTM 06-01;
- Ventilation, HTM 03-01.

The AE audit report recommended action plan is currently active, and the implementation of works are ongoing in accordance with the action plan recommendations.

7.0 Quality Improvement Plan/Areas for Improvement

Three AFIs 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 (DOH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

	Regulations	Standards
Total number of Areas for Improvement	1	2

AFIs and details of the QIP were discussed with Ms Denise Shields, Registered Manager, 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 Minimum Care Standards for Independent Health Establishments (2014)	
Area for improvement 1 **Ref:** Regulation 4 (c) **Stated:** First time **To be completed by:** 6 March 2022	The responsible individuals shall ensure that:- • medical staff receive suitable training in fire prevention. Ref: 5.3.2
	Response by registered person detailing the actions taken: Actions have been taken and the area for improvement has been addressed in full. Fire prevention training has been carried out for all Consultants and Doctors with Practising Privileges at Fitzwilliam Clinic by a trained professional. This is evidenced with an example certificate as submitted to RQIA..
Area for improvement 2 **Ref:** Standard 9 **Stated:** First time **To be completed by:** 6 March 2022	The responsible individuals shall ensure that:- • medicine audits include action plans and are validated by a senior manager; • environment audits of the clinical environment are commenced; and • action plans are underpinned by specific, measurable, achievable, realistic and timely (SMART) goals. Ref: 5.3.1
	Response by registered person detailing the actions taken: Actions have been taken for the area for improvement, addressing all three items in full • Medicine audits are checked and verified by the Registered Manager – signed and dated to this effect. Action plans include disposal of out of date medicines and detail medicines nearing expiry date. • Environment audits of the clinical environment have commenced and are undertaken by the Nurse Manager – supporting documentation has been provided as evidence. • All items for action have a date to be actioned by. Staff are given advice, guidance, training and achievable deadlines. Meaningful audits are carried out and feedback is given via minuted staff meetings.

Area for improvement 3 **Ref:** Standard 20 **Stated:** First time **To be completed by:** 6 March 2022	The responsible individuals shall ensure that:- • the domestic store is decluttered, cleaned and monitored; and • cleaning equipment is cleaned after use and appropriately stored. Ref: 5.8
	Response by registered person detailing the actions taken: Actions have been taken as follows and the area for improvement has been addressed and resolved in entirety • The domestic store was decluttered, cleaned and painted week commencing 11th January 2022. The store is monitored weekly by the supervisor and is included in the monthly clinical environment audit as carried out by the Nurse Manager. A copy of the environmental audit has been provided to RQIA. • The cleaning staff have been re-educated to appreciate how the equipment must be cleaned and stored before and after use. The store is decluttered and equipment is stored appropriately.

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

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