Announced Care Inspection Report
24 October 2016

Fitzwilliam Clinic

Type of service: Independent Hospital – Surgical Services
Address: 70-72 Lisburn Road, Belfast, BT9 6AF
Tel no: 028 9032 3888
Inspectors: Emily Campbell and Liz Colgan

1.0 Summary

An announced inspection of Fitzwilliam Clinic took place on 24 October 2016 from 10:00 to 17:35.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the independent hospital 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 Sheila Jordan, registered manager, and staff demonstrated that further development is needed to ensure that care provided to patients is 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. Three requirements and ten recommendations were made. Requirements made were in relation to the Private Doctor's current appraisal, medical emergency equipment and infection prevention and control. Six recommendations were in relation to recruitment, induction, appraisal and training records. A further four recommendations were in relation to surgical checklists, safeguarding, advanced life support training and infection prevention and control.

Is care effective?

Observations made, review of documentation and discussion with Ms Jordan and staff demonstrated that further development is needed to ensure that care provided in the establishment is effective. Areas reviewed included clinical records, the care pathway, patient information and decision making and discharge planning. Three recommendations were made in relation to patient records, consent forms and Venous Thromboembolism (VTE) risk assessment.

Is care compassionate?

Observations made, review of documentation and discussion with Ms Jordan 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. One recommendation was made to further develop the patient satisfaction survey summary report.

Is the service well led?

Information gathered during the inspection identified that further development is needed to ensure that effective leadership and governance arrangements are in place and create 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, 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 provider's understanding of their role and responsibility in accordance with

legislation. A requirement was made to update the statement of purpose and patient guide. Three recommendations were made in relation to Board meetings, complaints investigation records and the registration status in respect of categories of care.

A number of quality assurance processes were in place. However, evidence gathered during the inspection has identified a number of issues which could affect the delivery of safe and effective care, all of which have an impact on quality assurance and good governance. Four requirements and 17 recommendations in total have been made in order to progress improvement in identified areas. There is a lack of governance arrangements within the establishment and the requirements and recommendations made during this inspection must be actioned to ensure improvements are made. It is important these are kept under review to ensure improvements are sustained.

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	4	17

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Sheila Jordan, registered manager, 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

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 28 August 2015.

2.0 Service details

Registered organisation/registered person: Fitzwilliam Partnership James Small Andrew Kennedy Stephen Sinclair	**Registered manager:** Sheila Jordan
Person in charge of the home at the time of inspection: Sheila Jordan	**Date manager registered:** 13 January 2014

Categories of care:
AH(DS) - Acute Hospital (Day Surgery)
PD - Private Doctor
PT(L) - Prescribed Technologies, Laser
PT(IL) - Prescribed Technologies, Intense Light Source

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, complaints declaration and returned completed patient and staff questionnaires.

During the inspection the inspector met with Ms Jordan and two nurses and had a brief discussion with Mr Stephen Sinclair, registered person. 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
- 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.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 06 May 2016

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

4.2 Review of requirements and recommendations from the last care inspections dated 31 July 2016 and 28 August 2016

A care inspection was carried out on 31 July 2016 and a variation to registration care inspection was carried out on 28 August 2016 to include the category of care PT(IL), prescribed techniques intense light source. The requirement and recommendations from both inspections were reviewed during this inspection.

Last care inspection recommendations dated 31 July 2016		Validation of compliance
Recommendation 1 **Ref**: Standard 32.1 **Stated:** First time	It is recommended that the Venous Thromboembolism (VTE) risk assessment is discussed and agreed with the Medical Advisory Committee and implemented for all day surgery patients. Agreement should be sought on which medical practitioner is responsible for the completion of the risk assessment.	**Partially Met**
	Action taken as confirmed during the inspection: Review of six patient care records evidenced that the VTE risk assessment had been completed in respect of five patients. However, risk assessments had been completed by nursing staff; Ms Jordan advised that the anaesthetist reviewed these as part of their pre-operative assessment of the patient. There was no evidence in record reviewed to confirm that a medical practitioner had reviewed these. The appropriateness of nursing staff completing the VTE risk assessment was discussed given that the decision to prescribe thromboprophylaxis can only be made by a medical practitioner. The hospital's written protocol 'Guidelines for prophylaxis of VTE in Adult Patients' does not specify who is responsible for undertaking the risk assessment. One patient's record did not contain a VTE risk assessment. On further discussion with Ms Jordan it was identified that a VTE risk assessment is only completed if a patient is receiving a general anaesthetic. The Department of Health (DOH) and NICE guidance recommend that a risk assessment is completed for all patients undergoing surgery. It was noted that the hospital have adapted the recommended regional VTE risk assessment for their use.	

	A recommendation was made that: • a VTE risk assessment is completed for all patients undergoing surgery including those receiving local anaesthetic only • a determination should be made by the Fitzwilliam Clinic Board Group as to which medical practitioner is responsible for the completion of the risk assessment and prescribing thromboprophylaxis, if indicated • the determination of the Fitzwilliam Clinic Board Group should be included in the hospital's written protocol 'Guidelines for prophylaxis of VTE in Adult Patients' • consideration should be given to using the regional VTE risk assessment to provide a consistent regional approach. A copy of the DOH letter issued on 22 July 2011with guidance and the regional VTE was emailed to Ms Jordan on 25 October 2016.	
Variation to registration care inspection statutory requirements dated 28 August 2015		**Validation of compliance**
Requirement 1 **Ref:** Regulation 39 (2) **Stated:** First time	The registered manager must ensure that medical treatment protocols are developed as outlined in the main body of the report.	**Met**
	Action taken as confirmed during the inspection: Ms Jordan advised that laser and IPL services are no longer being provided at Fitzwilliam Clinic. This requirement was not reviewed during this inspection, however, the QIP submitted in respect of the variation to registration inspection on 28 August 2015 confirmed that the medical protocols had been developed. The categories of care that the hospital is currently registered for is discussed further in section 4.6 of the report.	

Variation to registration care inspection recommendations dated 28 August 2015		Validation of compliance
Recommendation 1 **Ref**: Standard 16.7 & 16.8 **Stated:** First time	It is recommended that the Statement of Purpose and Patient Guide are updated to include the IPL treatments offered by the establishment.	**Not Met**
	Action taken as confirmed during the inspection: Review of the statement of purpose and patient guide only made reference to the provision of laser services. As laser and IPL services are no longer provided the statement of purpose and patient guide need to be updated to reflect this. A requirement was made in this regard.	
Recommendation 2 **Ref**: Standard 48.17 **Stated:** First time	It is recommended that the LPA correctly identifies the disposable eye protection available within the establishment and amends the local rules accordingly.	**Met**
	Action taken as confirmed during the inspection: This recommendation was not reviewed during the inspection as laser and IPL services are no longer provided. The QIP submitted in respect of the variation to registration inspection on 28 August 2015 confirmed that the local rules had been amended to address this recommendation.	
Recommendation 3 **Ref**: Standard 48.6 **Stated:** First time	It is recommended that the LPA provides a report of his findings at each visit or signs a log retained within the clinic. Evidence of all ongoing correspondence with the LPA should also be retained.	**Met**
	Action taken as confirmed during the inspection: This recommendation was not reviewed during the inspection as laser and IPL services are no longer provided. The QIP submitted in respect of the variation to registration inspection on 28 August 2015 confirmed that evidence of the LPA's visits was provided.	

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, anaesthetists and nurses.

Review of the duty rotas for a four week period up to the date of the inspection confirmed that there was adequate staff in place to meet the assessed needs of the patients. Discussion with Ms Jordan confirmed that the theatre and outpatient clinic lists are reviewed and staff rostered accordingly to meet the needs of patients. A number of bank/relief nurses who have experience working in the hospital are available to ensure that adequate staffing levels are provided. Staff confirmed that there are adequate staffing levels provided to meet the patient's needs.

Ms Jordan confirmed that new staff are provided with an induction. However, there was no record of induction in the personnel file of the staff member recruited since the previous inspection. A recommendation was made that records of induction are completed and retained in personnel files of any new staff recruited.

Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place However, a review of three staff personnel files evidenced that two staff had not received appraisal in the last three years. Ms Jordan confirmed that she was planning to complete appraisals in the near future and one staff personnel file evidenced that the staff member had completed their appraisal preparation documentation in October 2016. Only contracted staff receive appraisal; however, there are a number bank/relief staff who provide cover on a regular basis. A recommendation was made that a system is established to ensure that all staff, including bank/relief staff, receive appraisal on an annual basis. Staff confirmed they felt supported and involved in discussions about their personal development.

There was some evidence of staff training in the personnel files reviewed; however' there was no system to record and monitor this in respect of all staff. A recommendation was made that a system is established 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 Jordan confirmed that a robust system was in place to review the professional indemnity status of all staff who require individual indemnity cover. Review of personnel files confirmed that medical practitioners had appropriate professional indemnity insurance in place and received the required annual appraisals, with the exception of one Private Doctor's appraisal record. A requirement was made that evidence of the Private Doctor's current appraisal is submitted to RQIA.

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

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

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

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

Recruitment and selection

Ms Jordan confirmed that one new staff member has been recruited since the previous inspection. A review of the personnel file for this staff member demonstrated that in general, the relevant information as outlined in Regulation 19 (2) Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained. However, the following issues were identified:

- there was no confirmation that the staff member was physically and mentally fit to fulfil the duties of their role
- evidence of the staff member's current professional body registration was available, however, there was no evidence that this was checked as part of the recruitment process.

A recommendation was made that the recruitment process is further developed to include this information and that it is retained in the personnel files of any new staff recruited.

Ms Jordan gave an assurance that an enhanced AccessNI check had been undertaken and received prior to the staff member commencing employment. However, although the unique identification number was retained, the dates the check was applied for and received and the outcome of the assessment of the check were not recorded. A recommendation was made that this information is retained in respect of any new staff recruited, in keeping with AccessNI's code of practice.

There was a recruitment policy and procedure available. This had been developed by an external recruitment service and detailed the information that should be provided in a recruitment policy, however, it had not been localised to reflect the arrangements in Fitzwilliam Clinic. A recommendation was made in this regard.

Surgical services

It was confirmed that 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 registered manager and surgeon. 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 six patient care records and discussion with staff confirmed that, where applicable, the anaesthetist who administers the anaesthetic visits the patient prior to surgery to:

- assess their general medical fitness
- review their medication
- explain the type of anaesthetic to be used
- discuss options for post-operative pain relief

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

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

Where applicable, 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 Ms Jordan confirmed that the surgical checklist based on the World Health Organisation (WHO) model is used in the hospital.

The clinical records of six patients were retrospectively reviewed who had previously undergone surgery in the clinic. The review evidenced that all surgical safety checklists were present in five records, however, a checklist was not present for a patient who had surgery carried out under local anaesthetic. On two occasions, not all sections of the checklist were ticked to indicate completion although all had two staff signatures. A recommendation was made that the surgical safety checklist is fully completed for every patient undergoing a surgical procedure, including local anaesthesia. Completion of the surgical safety checklists should be included in the hospital's clinical record audit programme.

Discussion with staff confirmed that patients are observed during surgery and in the recovery room on a one to one basis by staff trained in anaesthetics and resuscitation.

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

Laser Safety

Fitzwilliam Clinic is registered for the provision of laser and IPL categories of care. This service was provided by one staff member, who was the only authorised user. Ms Jordan advised that this staff member, following a period of planned leave has tendered their resignation and will not be returning to work in the establishment. Laser and IPL services have not been provided for a number of months and were therefore not reviewed during this inspection. The laser/IPL room

has been converted into a treatment room and the laser and IPL machines had been relocated to the Board Room for collection by the authorised user.

The registration for the provision of laser and IPL categories of care is discussed further in section 4.6 of this report.

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.

As discussed previously, a recommendation was made that a system is established for recording and monitoring all aspects of staff on-going professional development, including specialist qualifications and training. This should include safeguarding training. Ms Jordan confirmed that the adults safeguarding policy had not been updated to reflect the new regional guidance Adult Safeguarding Prevention and Protection in Partnership (July 2015). A recommendation was made that:

- the adult safeguarding policy is further developed to reflect the regional guidance
- the new regional guidance is made available to staff
- all staff are provided with update training in safeguarding adults at risk of harm
- safeguarding should be a topic covered during induction and update training provided to all staff every two years.

The revised adult safeguarding gateway numbers, for referral in the event of a concern being identified, were provided to Ms Jordan during the inspection.

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. Ms Jordan advised that a new emergency trolley had been obtained approximately six months ago. A list of emergency medications and equipment to be retained in the trolley was available and clearly identified their location within the trolley. A system was in place to check that emergency medicines and equipment do not exceed their expiry date. However, review of these identified that there was no razor available and a size 6 nasopharyngeal airway and 20ml syringes had exceeded their date of expiry. A requirement was made that these items are replaced and a robust system implemented to ensure that emergency medications and equipment do not exceed their expiry.

There was an identified individual with responsibility for checking emergency medicines and equipment.

Ms Jordan and staff spoken with confirmed that staff have undertaken basic life support training and updates and that some nursing staff had received modified advanced life support (ALS) training and updates. There is always at least one staff member with modified ALS on duty at all times. Ms Jordan could not explain the difference between ALS and modified ALS. A recommendation was made to ensure that there is at least one person on duty at all times with certified ALS in keeping with Standard 31.7 of the Minimum Care Standards for Independent Healthcare Establishments (July 2014). It is suggested that this level of training is provided to all permanent staff. Ms Jordan confirmed that all anaesthetists have advanced life support training.

Discussion with Ms Jordan 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.

Discussion with Ms Jordan and 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.

Ms Jordan confirmed that the policy for the management of medical emergencies reflected best practice guidance and protocols were available for staff reference outlining the local procedure for dealing with the various medical emergencies.

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.

The hospital contracts an independent IPC nurse to undertake audits and provide advice and guidance. A microbiologist is also similarly available to provide advice and guidance and to undertake visits if required. The independent IPC nurse had undertaken an audit on 22 July 2016. This highlighted a number of areas for improvement including the introduction of IPC audits undertaken by staff as a quality improvement initiative. A recommendation was made that an action plan to address the recommendations of the independent IPC audit should be devised. The action plan should identify timescales for completion and the name of the person responsible.

A tour of the premises was undertaken. These were generally clean and well maintained. There was a range of information for patients and staff regarding hand washing techniques.

A number of issues for improvement were identified which require to be addressed:

<u>Domestic store</u>

- The store was small and unfit for purpose. The room not clean and was cluttered with pieces of equipment stacked on top of each other. There were no storage shelves available. There was no dedicated hand washing sink for staff to use.

Theatre clean set up area

- The area was cluttered.
- A syringe and needle were sitting in a storage box with previously drawn up blue liquid. On discussion with staff, the liquid was identified as Methylene Blue Dye which is used in corrective ear surgery to mark the area. A staff member advised the dye had been in the syringe for approximately two months. The syringe was not labelled or dated. There were a number of areas of concern relating to this practice which were discussed with Ms Jordan in relation to storage in accordance with manufacturer's instructions, if it was a single use preparation, if there was a risk of contamination of the liquid and cross infection between usage and if there are any special disposal methods required.

Theatre Area

- The procedure IV trolley was dusty and stained in places and a black waste bag was attached to the trolley with a large clip. Ms Jordan removed the black waste bag during the inspection at the request of the inspectors.
- The sharps box on the resuscitation trolley was not dated or signed and the ambu-bag was uncovered.
- The computer keyboard was not wipeable.
- Systems and processes were in place for cleaning; however theatre cleaning schedules required more detail.

Theatre Dirty Room

- The room was cluttered and required cleaning. The yellow mop bucket and mop in the dirty room in theatre were soiled and the mop was not stored inverted. The suitability of the storage of the yellow mop bucket and mop in this area, which is used for cleaning clinical areas, should be reviewed. Three soiled scrubbers were noted at the waste disposal in this area, Ms Jordan disposed of these immediately.
- A purple lidded sharps box under the sink contained sharps and bottles, there was no lid present and the box was not signed or dated. Ms Jordan advised that this was the wrong box and shouldn't have been used.

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

Ms Jordan confirmed that staff have been provided with IPC training commensurate with their role. However, as previously discussed there is no oversight of training and a recommendation has been made in this regard.

The clinic monitors and records surgical site infections in patients returning to the clinic for follow up and these are recorded in the quarterly clinical and administration audit report. Ms Jordan confirmed she monitors surgical site infections for any underlying trends; however she does not document what procedures are being done by specific surgeons. The inspectors suggested this aspect is further developed.

Ms Jordan confirmed that there was a range of IPC policies and procedures in place.

Environment

The environment was maintained to a good standard of maintenance and décor.

The arrangements for maintaining the environment were not reviewed during this inspection. A premises inspection was undertaken by an estates inspector on 6 May 2016, and the requirements and recommendations made will be validated by the estates inspector at the next premises inspection.

Patient and staff views

Five patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm and that they were very satisfied with this aspect of care. The following comment was provided:

- "I felt very safe and comfortable throughout."

Two staff submitted questionnaire responses. Both indicated that they felt that patients are safe and protected from harm and that they were very satisfied with this aspect of care. No comments were included in submitted staff questionnaire responses.

Areas for improvement

Records of induction should be completed and retained in personnel files of any new staff recruited.

A system should be established to ensure that staff, including bank staff, receive appraisal on an annual basis.

A system should be established for recording and monitoring all aspects of staff ongoing professional development, including specialist qualifications and training.

Evidence of the Private Doctor's current appraisal should be submitted to RQIA.

The recruitment process should be further developed to include confirmation that the staff member is physically and mentally fit to fulfil the duties of their role and evidence of professional body registration, where applicable, in respect of any new staff recruited. Evidence should be retained in personnel files.

In keeping with AccessNI's code of practice, a record should be retained of the dates the enhanced AccessNI check was applied for and received, the unique identification number and the outcome of the check in respect of new staff recruited.

The recruitment policy should be further developed.

The surgical safety checklist should be fully completed for every patient undergoing a surgical procedure, including local anaesthesia. Completion of the surgical safety checklists should be included in the hospital's clinical record audit programme.

The adult safeguarding policy should be further developed to reflect the new regional guidance, guidance should be made available to staff and training should be provided to all staff.

A razor should be provided and size 6 nasopharyngeal airway and 20ml syringes replaced in the emergency medication and equipment trolley. A robust system implemented to ensure that emergency medications and equipment do not exceed their expiry.

There should be at least one person on duty at all times with certified ALS.

An action plan to address the recommendations of the independent IPC audit carried out on 22 July 2016 should be devised. The action plan should identify timescales for completion and the name if the person responsible.

Issues identified in relation to infection prevention and control should be addressed.

Number of requirements	3	**Number of recommendations**	10

4.4 Is care effective?

Care pathway

Ms Jordan confirmed that patients are provided with comprehensive information prior to their admission which outlines any pre-operative requirements and the arrangements for their stay in the hospital.

Six patient records reviewed found that the care records contained comprehensive information relating to peri-operative and post-operative care, however there was little evidence regarding initial consultations and pre-operative care. Records reviewed indicated that it was not always clear if a patient was seen prior to the day of surgery. In some records this assessment was either very brief or absent. Ms Jordan stated that consultants assess patients in different locations. There was little evidence that patients received correspondence about their surgery or the fees. In some notes there a scribbled note of cost or in one instance a sticky note was attached. To try and address this lack of information, nurses phone patients prior to surgery and obtain a medical history, results of blood or other tests and a other details relating to their surgery. The systems in place no not provide assurance that patients are adequately assessed and informed prior to surgery. A recommendation was made to implement a system to ensure that doctors consultation records are amalgamated with the hospital record to provide a clear and concise record of the patient's journey. This should include information provided in respect of costs for treatment.

Care records reviewed included the following:

- patient personal information
- holistic assessments
- pre-operative checks
- signed consent forms
- surgical safety checklist in five records
- operation notes
- anaesthetic notes
- medical notes
- intra-operative care plans
- recovery care plans

- post-operative care plans
- multidisciplinary notes
- a statement of the patient's condition prior to discharge
- discharge plan

Ms Jordan confirmed that the consultant surgeon discusses the nature of the surgery, the risks, complications and expected outcomes before signing the consent form. The consent forms reviewed by the inspectors were signed by the consultant surgeon and the patient. Some consent forms did not always include a full explanation of the procedure', 'intended benefits', 'information leaflet' and 'permission of photographs' and surgeon's signatures were not always legible or written in full. The monthly audit of records by the Ms Jordan identified that these are recurring issues. A recommendation was made in this regard.

As discussed previously in section 4.2, issues were identified in relation to the completion of the VTE risk assessment. A recommendation was made that:

- a VTE risk assessment is completed for all patients undergoing surgery including those receiving local anaesthetic only
- a determination should be made by the Fitzwilliam Clinic Board Group as to which medical practitioner is responsible for the completion of the risk assessment and prescribing thromboprophylaxis, if indicated
- the determination of the Fitzwilliam Clinic Board Group should be included in the hospital's written protocol 'Guidelines for prophylaxis of VTE in Adult Patients'
- consideration should be given to using the regional VTE risk assessment to provide a consistent regional approach.

As discussed previously, a recommendation was made regarding the surgical safety checklist.

Records

Systems were in place to audit the patient care records on a monthly basis. Ms Jordan was advised that the issues discussed regarding patient records should be included within future record audits.

Information was available for patients on how to access their health records, under the Data Protection Act 1998. However, Ms Jordan confirmed that the hospital does not have a Freedom of Information Publication Scheme and it was suggested that this should be developed.

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

Ms Jordan confirmed that the hospital 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.

Ms Jordan also confirmed that the hospital 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.

Discharge planning

The hospital has a discharge policy and procedure in place.

There are well developed discharge planning arrangements in place that require full engagement with patients.

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

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

Patient and staff views

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

- "I hold Mr Xxx in the highest esteem. He discussed every aspect of my care and follow up was excellent."

Both staff who submitted staff questionnaire responses indicated that they felt that patients get the right care, at the right time and with the best outcome for them and that they were very satisfied with this aspect of care. Staff spoken with during the inspection concurred with this. No comments were included in submitted staff questionnaire responses.

Areas for improvement

A system should be implemented to ensure that doctors consultation records are amalgamated with the hospital record to provide a clear and concise record of the patient's journey. This should include information provided in respect of costs for treatment.

Consent forms should be fully completed and surgeon's signatures should be legible and written in full.

A VTE risk assessment should be completed for all patients undergoing surgery including those receiving local anaesthetic only. Issues identified in relation to the completion of the assessment should be addressed.

Number of requirements	0	**Number of recommendations**	3

4.5 Is care compassionate?

Dignity, respect and rights

Discussion with Ms Jordan regarding the consultation and treatment process confirmed that patient's modesty and dignity is respected at all times. Private consultation rooms were observed to be provided for patients to meet with the medical practitioners containing modesty screens. Private individual changing rooms are available close to the theatre. The establishment has a recovery area that can accommodate up to two patients which are in close proximity with each other and divided by curtains. The design and size presents challenges to nursing and medical staff in ensuring the privacy and confidential of patients. Ms Jordan confirmed that, where possible, only one patient will be cared for in the recovery area at a time.

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.

Ms Jordan confirmed that 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 Ms Jordan and staff 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 within locked filing cabinets within a secure room. Electronic records are accessed using individual user names and passwords.

Staff were observed treating patients with compassion, dignity and respect. No patients wished to speak with the inspectors at the time of inspection.

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

Ms Jordan confirmed that 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.

Ms Jordan 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, Ms Jordan confirmed that consent must be obtained from the patient and documented in the patient's records.

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

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

Patient consultation

The establishment obtains the views of patients and/or their representatives on a formal and informal basis as an integral part of the service they deliver.

Patients are offered the opportunity to complete a satisfaction questionnaire within the hospital. The information received from the patient feedback questionnaires is collated into an annual summary report which is made available to patients and other interested parties to read within the establishment. However, the summary report provided for patients only includes if patients would recommend the hospital and it did not include the number of patients who participated in the survey. A more detailed report is included in the hospital's quarterly clinical and administration audit report which includes comments provided by patients and an action plan to progress improvement in identified areas; however, this also does not reflect the findings of the collation of all questions in the survey or the number of patients who participated. A recommendation was made that the patient satisfaction survey summary report made available to patients is further developed to include the results of all questions, the number of patients who participated in the survey and the action plan.

Comments provided by patients in the most recent quarterly clinical and administration audit report included the following:

- "Everyone very helpful and good at answering questions. Thank you."
- "Care from the start to the end was absolutely superb. Mr Small is a top class surgeon and his team very knowledgeable and helpful and kind."
- "Most helpful and friendly place I've ever been. Wonderful staff."
- "I was delighted at how quick and efficient the whole procedure is."
- "Everyone friendly – all well explained."
- "This is my second post surgery review. On my first appointment I had to wait 10 minutes to be seen. This appointment I waited 50 minutes. The waiting time is unsatisfactory."
- "Very pleased with the overall treatment."
- "Everything was very good. I would recommend it to my friends."

Patient and staff views

All patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care and that they were very satisfied with this aspect of care. The following comment was provided:

- "I was treated with great dignity and respect and privacy was protected."

Both staff who 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. One staff member indicated that they were very satisfied and one that they were satisfied with this

aspect of care. Staff spoken with during the inspection concurred with this. No comments were included in submitted staff questionnaire responses.

Areas for improvement

The patient satisfaction survey summary report made available to patients should be further developed.

Number of requirements	0	Number of recommendations	1

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. There was a nominated individual with 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. As discussed previously a clinical and administration audit report is compiled on a quarterly basis and includes information on theatre figures, infection/compliance rates, patient satisfaction, emergency/re-operation audit, incidents, complaints, training and record audits. The hospital Board medical advisory committee used to meet on approximately a quarterly basis and the audit report would have been discussed within this. Ms Jordan confirmed that minutes are retained of these meetings. However the hospital Board have not met since 2014 and there was no evidence that members of the Board had collectively reviewed and discussed the findings of the audit. A recommendation was made that Board meetings are re-instated.

Ms Jordan advised that staff meetings are held on a two to three monthly basis and minutes are retained, however, minutes are not available to staff who were unable to attend the meeting. Ms Jordan agreed to ensure all staff have access to the minutes of staff meetings. There is an informal daily meeting with staff each morning to discuss the arrangements for the day.

Policies and procedures were available for staff reference which are reviewed on at least a three yearly basis. It was suggested that the index system is reviewed to facilitate clearer access to policies.

A copy of the complaints procedure was available in the hospital. Ms Jordan demonstrated a good awareness of complaints management. A complaints questionnaire was forwarded by RQIA to the hospital for completion and the returned questionnaire confirmed that some complaints had been received. Review of a random selection of complaints investigation records and discussion with Ms Jordan, evidenced that the investigation records lacked detail and responses provided to patients were not always clear. A recommendation was made that the complaints investigation process is further developed to include detailed records of all aspects of the investigation and the outcome of the investigation. The response provided to patients should clearly reflect the outcome of the investigation and if appropriate any actions implemented to prevent a similar recurrence.

Ms Jordan 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. This included:

- clinical records
- accidents and incidents
- complaints
- infection prevention and control
- post surgery infections
- emergency/re-operations
- patient satisfaction.

Implementation of the recommendations made in the independent IPC audit, as discussed in section 4.3, will further enhance the hospital's audit programme.

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. Ensuring that staff receive annual appraisal will further enhance this process.

Five medical practitioner's personnel files 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. As discussed previously there was no evidence available of the Private Doctor's current appraisal and a requirement was made that this is submitted to RQIA.

There are systems in place to review practising privileges agreements every two years. Ms Jordan confirmed that the hospital 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 Jordan demonstrated a clear understanding of her role and responsibility in accordance with legislation. However, as discussed in section 4.2, the recommendation made during the previous inspection to update the statement of purpose and patient guide to include the IPL treatments offered by the establishment had not been addressed. No laser or IPL services are now being provided, however, the statement of purpose and patient guide have still not been updated to reflect this. A requirement was made in this regard.

The RQIA certificate of registration was displayed appropriately. Fitzwilliam Clinic is registered for the provision of laser and IPL categories of care. This service was provided by one staff member, who was the only authorised user. Ms Jordan advised that this staff member, following a period of planned leave has tendered their resignation and will not be returning to work in the establishment. Laser and IPL services have not been provided for a number of months and the laser/IPL room has been converted into a treatment room. A recommendation was made that an application of variation should be submitted to RQIA to deregister the laser and IPL categories of care.

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

Evidence gathered during the inspection has identified a number of issues which could affect the delivery of safe and effective care, all of which have an impact on quality assurance and good governance. Four requirements and 17 recommendations have been made in order to progress improvement in identified areas. There is a lack of governance arrangements within the establishment and the requirements and recommendations made during this inspection must be actioned to ensure improvements are made. It is important these are kept under review to ensure improvements are sustained.

Patient and staff views

All patients who submitted questionnaire responses indicated that they felt that the service is well managed and that they were very satisfied with this aspect of care. The following comment was provided:

- "Mr Small took time and patience to answer any concerns. His manner is beyond compare. An excellent medical professional."

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

Areas for improvement

The hospital Board medical advisory committee meetings should be re-instated and held at least every three months.

The complaints investigation process should be further developed and the response provided to patients should clearly reflect the outcome of the investigation.

The statement of purpose and patient guide should be updated to reflect that laser and IPL treatments are no longer offered by the establishment.

An application of variation should be submitted to RQIA to deregister the laser and IPL categories of care.

Number of requirements	1	**Number of recommendations**	3

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Sheila Jordan, registered manager, 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 Independent.Healthcare@rqia.org.uk 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

Statutory requirements

Requirement 1 **Ref**: Regulation 18 (3) **Stated:** First time **To be completed by:** on submission of Quality Improvement Plan	The registered provider must submit evidence of the Private Doctor's current appraisal to RQIA.
	Response by registered provider detailing the actions taken: I have contacted the Private Dr and he has assured me that he has an appointment booked at the end of November 2016 for his revalidation His annual appraisal will be updated at the same time and I can confirm this once I receive evidence of completion.
Requirement 2 **Ref:** Regulation 15 (2) **Stated:** First time **To be completed by:** 30 October 2016	The registered provider must ensure that a razor should be provided and size 6 nasopharyngeal airway and 20ml syringes replaced in the emergency medication and equipment trolley. A robust system implemented to ensure that emergency medications and equipment do not exceed their expiry.
	Response by registered provider detailing the actions taken: Items listed above have been replaced on the trolley. The clinic has a system for routine monthly checks but unfortunately on the occasion it was not thoroughly done. An incident form has been completed about this. These are discussed at staff meetings.
Requirement 3 **Ref:** Regulation 15 (7) **Stated:** First time **To be completed by:** 24 December 2016	The registered provider must ensure that the issues identified in relation to infection prevention and control as identified in the body of the report are addressed.
	Response by registered provider detailing the actions taken: Issues identified in relation to infection prevention and control will be addressed by 24th Dec 2016.
Requirement 4 **Ref:** Regulation 9 **Stated:** First time **To be completed by:** 24 November 2016	The registered provider must ensure that statement of purpose and patient guide are updated to reflect that laser and IPL treatments are no longer offered by the establishment.
	Response by registered provider detailing the actions taken: The statement of purpose and patient guide have been updated to reflect that laser and IPL treatments are no longer offerred by ourselves.

Recommendations	
Recommendation 1 **Ref**: Standard 13.3 **Stated:** First time **To be completed by:** 25 October 2016	Records of induction should be completed and retained in personnel files of any new staff recruited.
	Response by registered provider detailing the actions taken: Records of induction have been completed and filed in the staff files.
Recommendation 2 **Ref**: Standard 13.9 **Stated:** First time **To be completed by:** 24 January 2017	A system should be established to ensure that staff, including bank staff, receive appraisal on an annual basis.
	Response by registered provider detailing the actions taken: All permanent nursing staff will have appraisals completed on an annual basis. We will introduce appraisals for regular bank staff also. This will be completed by 24th Jan 2017
Recommendation 3 **Ref**: Standard 13.4 **Stated:** First time **To be completed by:** 24 January 2017	A system should be established for recording and monitoring all aspects of staff ongoing professional development, including specialist qualifications and training.
	Response by registered provider detailing the actions taken: A system will be established for recording and monitoring all aspects of ongoing professional staff development. This will be completed by 24th Jan 2017
Recommendation 4 **Ref**: Standard 14.2 **Stated:** First time **To be completed by:** 25 October 2016	The recruitment process should be further developed to include confirmation that the staff member is physically and mentally fit to fulfil the duties of their role and evidence of professional body registration, where applicable, in respect of any new staff recruited. Evidence should be retained in personnel files.
	Response by registered provider detailing the actions taken: Future recruitment will confirm that staff members are physically and mentally fit to fulfil the duties of their role. This will also be retained in their personnel file.
Recommendation 5 **Ref**: Standard 14.3 **Stated:** First time **To be completed by:** 25 October 2016	In keeping with AccessNI's code of practice, a record should be retained of the dates the enhanced AccessNI check was applied for and received, the unique identification number and the outcome of the check in respect of any new staff recruited.
	Response by registered provider detailing the actions taken: Future recruitment will include a record of enhanced AccessNI check,dates applied for and received. The unique ID number and outcome will be documented.

Recommendation 6 **Ref**: Standard 14.1 **Stated:** First time **To be completed by:** 24 January 2017	The recruitment policy should be further developed to ensure it is reflective of best practice guidance. The policy should include the following; open recruitment process, advertising, application process, shortlisting, interview & selection process, issuing of job description and contract of employment, employment checks, references, employment history, AccessNI, health, professional qualifications.
	Response by registered provider detailing the actions taken: The recruitment policy will be further developed as requested and will be completed by 24th Jan 2017.
Recommendation 7 **Ref**: Standard 32.1 **Stated:** First time **To be completed by:** 24 November 2016	The surgical safety checklist should be fully completed for every patient undergoing a surgical procedure, including local anaesthesia. Completion of the surgical safety checklists should be included in the hospital's clinical record audit programme.
	Response by registered provider detailing the actions taken: We have introduced a surgical safety checklist for all patients including local anaesthetic procedures.
Recommendation 8 **Ref**: Standard 3 **Stated:** First time **To be completed by:** 24 January 2017	The adult safeguarding policy should be further developed to reflect the new regional guidance Adult Safeguarding Prevention and Protection in Partnership (July 2015). A copy of the new regional guidance should be available to staff. Staff should be provided with update training in safeguarding adults at risk of harm. Safeguarding should be a topic covered during induction and update training provided to all staff every two years. Records should be retained.
	Response by registered provider detailing the actions taken: The adult safeguarding policy will be developed to reflect the new regional guidance. This will be made available to all staff alongside the appropriate training. Records will be retained of staff training. This will be completed by Jan 24th 2017
Recommendation 9 **Ref**: Standard 31.7 **Stated:** First time **To be completed by:** 24 January 2017	Ensure there is at least one person on duty at all times with certified advanced life support (ALS) training. Records should be retained.
	Response by registered provider detailing the actions taken: Presently we have at least one staff member on duty at all times with the modified ALS. This course is provided by Survival Linx Solutions. I will have confirmed by 24th Jan 2017 an update on the need for ALS.

Recommendation 10 **Ref**: Standard 20 **Stated:** First time **To be completed by:** 24 December 2016	An action plan to address the recommendations of the independent IPC audit carried out on 22 July 2016 should be devised. The action plan should identify timescales for completion and the name if the person responsible.
	Response by registered provider detailing the actions taken: This action plan will be addressed and completed by 24th Dec 2016
Recommendation 11 **Ref**: Standard 6.7 **Stated:** First time **To be completed by:** 24 November 2016	A system should be implemented to ensure that doctors consultation records are amalgamated with the hospital record to provide a clear and concise record of the patient's journey. This should include information provided in respect of costs for treatment.
	Response by registered provider detailing the actions taken: A system has been implemented to ensure doctors consultation records are amalgamated.
Recommendation 12 **Ref**: Standard 2 **Stated:** First time **To be completed by:** 25 October 2016	Consent forms should be fully completed and surgeon's signatures should be legible and written in full.
	Response by registered provider detailing the actions taken: Consent forms are now being fully completed with surgeons signatures and are being audited on a monthly basis.
Recommendation 13 **Ref**: Standard 32.1 **Stated:** First time **To be completed by:** 24 November 2016	A Venous Thromboembolism (VTE) risk assessment should be completed for all patients undergoing surgery including those receiving local anaesthetic only. A determination should be made by the Fitzwilliam Clinic Board Group as to which medical practitioner is responsible for the completion of the risk assessment and prescribing thromboprophylaxis, if indicated. The determination of the Fitzwilliam Clinic Board Group should be included in the hospital's written protocol 'Guidelines for prophylaxis of VTE in Adult Patients'. Consideration should be given to using the regional VTE risk assessment to provide a consistent regional approach.
	Response by registered provider detailing the actions taken: VTE risk assessments are now being completed for all patients including those having local anaesthetic procedures. It has been determined that the surgeon should complete the VTE risk assessment and prescribe thromboprophylaxis if indicated. This has been included in the clinic's written protocol for prophylaxis of VTE in Adult patients. The clinic is now using the regional VTE risk assessment.

Recommendation 14 **Ref**: Standard 5 **Stated:** First time **To be completed by:** 24 January 2017	The patient satisfaction survey summary report made available to patients should be further developed to include the results of all questions, the number of patients who participated in the survey and the action plan.
	Response by registered provider detailing the actions taken: Patient satisfaction survey will be further developed to include results and number of participants. This will be completed by 24th Jan 2017
Recommendation 15 **Ref**: Standard 30.6 **Stated:** First time **To be completed by:** 24 January 2017	The hospital Board medical advisory committee meetings should be re-instated and held at least every three months.
	Response by registered provider detailing the actions taken: Fitzwiiliam Clinic will reinstate the above committee meetings at least every 3 months. This will be completed by 24th Jan 2017
Recommendation 16 **Ref**: Standard 7.8 **Stated:** First time **To be completed by:** 24 November 2016	The complaints investigation process should be further developed to include detailed records of all aspects of the investigation and the outcome of the investigation. The response provided to patients should clearly reflect the outcome of the investigation and if appropriate any actions implemented to prevent a similar recurrence.
	Response by registered provider detailing the actions taken: The complaints investigation process will be further developed to include all aspects and the outcome of the investigation. The response to patients will clearly reflect the outcome and any appropriate actions to be implemented to prevent recurrence.
Recommendation 17 **Ref**: Standard 16 **Stated:** First time **To be completed by:** 24 December 2016	An application of variation to de-register the laser and IPL categories of care should be submitted to RQIA.
	Response by registered provider detailing the actions taken: We will de-register the laser and IPL categories of care and submit it to RQIA by 24th Dec 2016.

Please ensure this document is completed in full and returned to Independent.Healthcare@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

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