Announced Inspection

Name of Establishment:	**Fitzwilliam Clinic**
Establishment ID No:	**10637**
Date of Inspection:	**30 July 2014**
Inspector's Name:	**Jo Browne**
Inspection No:	**17481**

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1.0 General Information

Name of establishment:	Fitzwilliam Clinic
Address:	70 - 72 Lisburn Road Belfast BT9 6AF
Telephone number:	028 9032 3888
Registered organisation/ registered provider:	Fitzwilliam Partnership Mr James Small Mr Stephen Sinclair Mr James Kennedy
Registered manager:	Ms Sheila Jordan
Person in charge of the establishment at the time of inspection:	Ms Sheila Jordan
Registration category:	AH (DS) – Acute Hospital Day Surgery PT(L) - Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers PD – Private Doctor (Other)
Date and time of inspection:	30 July 2014 09.50 am – 17.00pm
Date and type of previous inspection:	Announced Inspection 12 September 2013
Name of inspector:	Jo Browne

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect independent health care establishments. A minimum of one inspection per year is required.

This is a report of the announced inspection to assess the quality of services being provided. The report details the extent to which the regulations and DHSPPS Minimum Care Standards for Independent Healthcare Establishments, July 2014, measured during the inspection were met.

2.1 Purpose of the Inspection

The purpose of this inspection was to ensure that the service is compliant with relevant regulations, the minimum standards and to consider whether the service provided to patients was in accordance with their assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, procedures, practices and monitoring arrangements for the provision of an independent hospital, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Independent Health Care Regulations (Northern Ireland) 2005
- The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011
- The Department of Health, Social Services and Public Safety's (DHSSPS) Minimum Care Standards for Independent Healthcare Establishments

Other published standards which guide best practice may also be referenced during the inspection process.

2.2 Methods/Process

Committed to a culture of learning, RQIA has developed an approach which uses self-assessment, a critical tool for learning. The self-assessment was forwarded to the provider prior to the inspection and was reviewed by the inspector prior to the inspection. The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.

Specific methods/processes used in this inspection include the following:

- Analysis of pre-inspection information and self-assessment
- Discussion with Ms Sheila Jordan, registered manager
- Discussion with Mrs Kelly Buckley, practice manager
- Examination of records
- Tour of the premises
- Evaluation and feedback

Any other information received by RQIA about this registered provider and its service delivery has also been considered by the inspector in preparing for this inspection.

The completed self-assessment is appended to this report.

2.3 Consultation Process

During the course of the inspection, the inspector:

Spoke with Staff	2
Reviewed completed patient satisfaction questionnaires	75

2.4 Inspection Focus

The inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Minimum Care Standards for Independent Healthcare Establishments and to assess progress with the issues raised during and since the previous inspection.

- Standard 5 Patient and Client Partnerships
- Standard 6 Care Pathway
- Standard 7 Complaints
- Standard 9 Clinical Governance
- Standard 16 Management and Control of Operations
- Standard 31 Resuscitation
- Standard 32 Surgery

3.0 Profile of Service

The Fitzwilliam Clinic is a situated in a converted residential building located on the Lisburn Road in Belfast. The hospital offers a range of surgical and non-surgical procedures. The clinic has no overnight beds and all surgery is performed as day cases only.

The following procedures are available in the clinic:

Surgery

- Cutaneous surgery
- Oral surgery
- Breast surgery
- Hand surgery
- Aesthetic surgery
- General surgery
- Varicose Vein Treatments using radiofrequency abalation
- Waiting list initiative procedures for local HSC trusts

All surgical procedures are undertaken by consultant medical practitioners and dental practitioners who have been granted practising privileges by the hospital.

The acting manager is Ms Sheila Jordan. Mr Stephen Sinclair is the medical director/responsible individual for the hospital. Mr Small and Mr Kennedy are also partners in the business and responsible individuals.

Laser Services

The hospital has ceased providing laser services and the laser room on the first floor has been converted into a treatment room.

Treatment Room

A variation application was received by RQIA on 13 March 2014 to convert the first floor laser room into a treatment room. The registered manager informed the inspector that the treatment room will be used for minor operative procedures and varicose vein treatments. The treatment room was reviewed as part of this inspection and the variation application was approved from a care perspective. An estates inspection will also be undertaken in relation to the variation application and will generate a separate report.

Private and on street car parking is available for patients and visitors.

The hospital is accessible for patients with a disability.

Fitzwilliam Clinic is registered as an independent hospital with the AH(DS), PT(L) and PD categories of registration.

4.0 Summary of Inspection

An announced inspection was undertaken by Jo Browne on 30 July 2014 from 09.50 am to 17.00pm. The inspection sought to establish the compliance being achieved with respect to 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, the DHSPPS Minimum Care Standards for Independent Healthcare Establishments and to assess the progress made to address the issues raised during the previous inspection.

There were three requirements and five recommendations made as a result of the previous annual announced inspection on 12 September 2013. All of the requirements and recommendations have been fully addressed.

The inspection focused on the DHSPPS Minimum Care Standards for Independent Healthcare Establishments outlined in section 2.4 of this report.

Ms Sheila Jordan was available during the inspection and for verbal feedback at the conclusion of the inspection. Ms Jordan has been the registered manager since January 2014 and prior to this appointment she was employed as a senior nurse within the establishment.

During the course of the inspection the inspector discussed operational issues, examined a selection of records and carried out a general inspection of the hospital.

There are robust systems in place to obtain the views of patients. The inspector reviewed the completed patient questionnaires, along with the summary reports and found that patients were highly satisfied with the quality of care and treatment provided. Comments received from patients can be viewed in the main body of the report. Feedback from patients is used by the management of the hospital to improve patient services.

Patients are provided with a comprehensive information pack prior to their admission which outlines any pre-operative requirements, post-operative instructions and the arrangements for admission to the establishment. The establishment only provides day surgery services.

The inspector reviewed the care records of eight patients undergoing surgery and found them to be well completed. There was a clear pathway of care recorded from the initial consultation, to informed consent, to admission, through pre-operative care, intra-operative care, post-operative care, review and discharge.

A discharge letter summarising the patient's treatment and care is sent to the patient's general practitioner (GP) and any other relevant professionals who are involved in ongoing care and treatment, with the consent of the patient.

The hospital's complaints policy and procedure is in line with the DHSSPS guidance and legislation. The inspector reviewed complaints management within the establishment and found that complaints were well documented, fully investigated and had outcomes recorded.

The registered manager is responsible for the day to day running of the establishment and ensuring compliance with the legislation and standards.

The hospital has systems in place to audit and monitor the quality of clinical care provided. The inspector reviewed audits and quality of clinical care indicators as outlined in the main body of the report.

The inspector reviewed incident management and found that incidents were well documented, fully investigated and had outcomes recorded. Some incidents had not been reported to RQIA in line with the legislation due to a misunderstanding of the guidance and a requirement was made to address this. Audits of incidents were undertaken as part of the hospital's clinical governance systems. Arrangements were in place to disseminate learning outcomes throughout the organisation.

The registered manager confirmed that no research is currently being undertaken within the hospital.

There is a defined management structure within the hospital and clear lines of accountability.

The inspector reviewed the policy and procedures in relation to the absence of the registered manager and whistle blowing. They were found to be in line with legislation and best practice.

The registered manager undertakes ongoing training to ensure that she is up to date in all areas relating to the provision of services.

A Statement of Purpose and Patient Guide were in place which reflected legislative and best practice guidance.

The inspector confirmed that appropriate meals are provided in line with the assessed needs of the patients. Light refreshments are provided to day surgery patients prior to discharge.

Systems are in place to ensure any agency staff used within the hospital are recruited in line with the hospital's recruitment procedures and undertake an induction programme.

The inspector reviewed the insurance arrangements for the hospital and found that current insurance policies were in place.

There is a written resuscitation policy in place. Staff had received basic life support training and updates and all theatre staff have received advanced life support

training. There is always at least one staff member with advanced life support training on duty at all times.
There is a range of resuscitation equipment in place which is checked and restocked to ensure all equipment remains in working order and is suitable for use at all times. A recommendation was made to include the drugs used in a medical emergency and the number of fluid bags to be retained on the resuscitation trolley on the check list.

The establishment has a range of policies and procedures for surgical procedures which are in accordance with good practice guidelines and national standards.

The scheduling of patients is co-ordinated by the registered manager, team leaders and administration staff. The theatre lists take into account the individual requirements of the patient, the type of procedure to be undertaken, equipment required, associated risks and the level of sedation used.

The inspector reviewed the facilities and discussed the management of intraoperative care and immediate post op care. The registered manager displayed a good understanding of the topics discussed. It was recommended that the name of the team leader in theatre is identified on the off duty to ensure that a permanent record is retained.

A review of theatre practices is due to be undertaken by a separate team of RQIA inspectors on 14 August 2014. A copy of the review report will be forwarded to the hospital and made available on the RQIA website.

The inspector observed that laser warning signs were displayed outside theatre. As lasers are not used in the theatre area it was recommended that the warning signs were removed.

Overall, on the day of inspection, the hospital was found to be providing a quality, safe and effective service to patients.

The certificates of registration and insurance were clearly displayed in the premises.

There was one requirement and three recommendations made as result of this inspection. These are discussed fully in the main body of the report and in the appended Quality Improvement Plan.

The inspector would like to thank Ms Sheila Jordan, Mrs Kelly Buckley, patients and staff of Fitzwilliam Clinic for their hospitality and contribution to the inspection process.

5.0 Follow Up on Previous Issues

No.	Regulation Ref.	Requirements	Action taken as confirmed during this inspection	Number of times stated	Inspector's validation of compliance
1	18 (3)	The acting manager must ensure that all information, required by legislation and outlined in the main body of the report, is retained by the hospital for medical staff who have been granted practising privileges.	Review of the personnel files for medical practitioners confirmed that all information required by legislation had been retained.	One	Compliant
2	15 (2)	The acting manager must ensure that all sterile equipment within the resuscitation trolley has not exceeded its expiry date.	Review of the contents of the resuscitation trolley confirmed that all sterile equipment was not past its expiry date.	One	Compliant
3	15 (7)	The acting manager must ensure that all staff dispose of syringes in line with best practice guidance.	A review of the environment confirmed that sharps had been disposed of in line with best practice guidelines.	One	Compliant

No.	Minimum Standard Ref.	Recommendations	Action taken as confirmed during this inspection	Number of times stated	Inspector's validation of compliance
1	C4.2	The acting manager should ensure that a summary report of the patient satisfaction survey is made available for patients and other interested parties to read.	The inspector observed that a copy of the summary report of the patient satisfaction survey is made available to patients and other interested parties in the waiting room.	One	Compliant
2	C5.1	The acting manager should ensure that the complaints policy and procedure is updated as outlined in the main body of the report.	The inspector reviewed the complaints policy and procedure and found it to be in line with the legislation.	One	Compliant
3	C16.2	The acting manager should develop an overarching management of records policy as outlined in the main body of the report.	The inspector confirmed that an overarching management of records policy had been developed.	One	Compliant
4	A1.10	The acting manager should update the discharge criteria form to enable the identification of the nurse completing the form and the medical practitioner who agreed that the patient was fit for discharge.	The inspector observed that the discharge form had been updated to include the name of the medical practitioner who agreed that the patient was fit for discharge.	One	Compliant
5	A22.4	The acting manager should ensure that the system for evidencing when specimen results have been received is reviewed to ensure a consistent approach is maintained.	The registered manager confirmed that nursing staff check the specimen book on a weekly basis to ensure that all results have been returned.	One	Compliant

6.0 Inspection Findings

STANDARD 5	
Patient and Client Partnerships:	**The views of patients and clients, carers and family members are obtained and acted on in the evaluation of treatment, information and care**

Fitzwilliam Clinic obtains the views of patients on a formal and informal basis as an integral part of the service they deliver.

The establishment issued feedback questionnaires to surgical and dermatology patients and 75 were returned and completed. The inspector reviewed the completed questionnaires and found that patients were highly satisfied with the quality of treatment, information and care received. Comments from patients included:

- "Could not be improved, perfect"
- "Staff excellent, very hospitable in every way from reception to Doctor Kennedy. All very friendly and helpful"
- "Excellent staff and very professional"
- "It was all good"
- "Seen quickly by excellent staff"
- "Excellent treatment throughout"
- "I was treated with utmost care"
- "Very efficient and welcoming and put me at ease. Would recommend anyone without hesitation"
- "Very good service"
- "Superb, sensitive and honest. Also tremendous skill and expertise"

The information received from the patient feedback questionnaires is collated into a quarterly summary report which is made available to patients and other interested parties to read within the patient information file in the waiting area.

The results of the patient feedback are reviewed by the management team within the hospital and an action plan is developed and implemented if any issues are identified.

Evidenced by:

Review of patient satisfaction surveys
Review of summary report of patient satisfaction surveys
Summary report made available to patients and other interested parties
Discussion with staff

STANDARD 6	
Care Pathway:	**Patients and clients have a planned programme of care from the time of referral to a service through to discharge and continuity of care is maintained.**

Patients are provided with a comprehensive information pack prior to their admission which outlines any pre-operative requirements and the arrangements for their stay as a day case within the hospital.

The establishment has a wide range of information leaflets available regarding the types of procedures available. The registered manager confirmed that information can be provided in an alternative language or format if required.

A range of clinical assessments are undertaken by the different members of the health care team prior to surgery and the outcomes are recorded in the individual patient care records.

The inspectors reviewed the care records of eight patients and found that the care records contained comprehensive information relating to pre-operative, intra-operative and post-operative care which clearly outlined the patient pathway and included the following:

- Patient personal information
- Holistic assessments
- Pre-operative care plans
- Pre-operative checks
- Signed consent forms
- Surgical safety checklist (Modified WHO)
- Operation notes
- Anaesthetic notes
- Medical notes
- Intra-operative care plans
- Recovery care plans
- Post-operative care plans
- Multidisciplinary notes
- Statement of the patient's condition
- Discharge plan

Review of the care records confirmed that patients are involved in planning their care and treatment.

The registered manager confirmed that the results of investigations and treatment provided is explained to the patients and future treatment options are discussed and patients are involved in the decision making process.

Following the previous inspection the inspector observed that the discharge form had been updated to include the name of the medical practitioner who agreed that the patient was fit for discharge.

The hospital has developed a new discharge brochure which is provided to all patients and contains information regarding their procedure and relevant contact numbers if the patient has any concerns.

A discharge letter summarising the patient's treatment and care is sent to the patient's general practitioner (GP) and any other relevant professionals who are involved in ongoing care and treatment.

All patients are contacted the day following their surgery by a member of the nursing staff to deal with any queries or concerns they may have.

Evidenced by:

Review of patient care records
Discussion with staff
Discharge plan and letter to GP or other relevant professionals

STANDARD 7	
Complaints:	**All complaints are taken seriously and dealt with appropriately and promptly.**

The establishment operates a complaints policy and procedure in accordance with the DHSSPS guidance on complaints handling in regulated establishments and agencies and the legislation. The complaints procedure distinguishes between the onward referral routes for private patients and waiting list initiative patients if they remain dissatisfied with the outcome of the complaints procedure.

The practice manager is the complaints manager for the hospital. The registered manager and practice manager demonstrated a good understanding of complaints management.

All patients are provided with a copy of the complaints procedure, which is contained within the Patient Guide and in the patient information file in the waiting area. The registered manager confirmed that the complaints procedure could be made available in alternative formats and languages if required.

The inspector reviewed the complaints register and complaints records. All complaints were well documented, fully investigated and had outcomes recorded in line with the complaints procedure and legislation.

The registered manager undertakes an audit of complaints every 3 months as part of the establishment's quality assurance mechanisms. The audit information is used to identify trends and enhance services provided as part of the hospital's clinical governance arrangements.

Evidenced by:

Review of complaints procedure
Complaint procedure made available to patients and other interested parties
Discussion with staff
Review of complaints records
Review of the audit of complaints

STANDARD 9	
Clinical Governance:	**Patients and clients are provided with safe and effective treatment and care based on best practice guidance, demonstrated by procedures for recording and audit.**

The registered manager ensures the establishment delivers a safe and effective service in line with the legislation, other professional guidance and minimum standards.

Discussion with the registered manager and review of specific training records and policies and procedures confirmed that systems are in place to ensure that staff receive appropriate training when new procedures are introduced.

The establishment has systems in place to audit the quality of service provided. The inspector reviewed the following audits as part of the inspection process:

- Complaints Audit
- Infection prevention and control Audit
- Clinical incident Audit
- Patient records Audit
- Clinical and Administration Audit Report

Systems are in place to ensure that the registered partners are kept informed regarding the day to day running of the establishment. The registered persons are regularly in the hospital providing medical services and attend monthly board meetings of which minutes are retained. The registered manager confirmed there is excellent communication with the registered persons and they are kept fully informed as to the conduct of the hospital.

Systems are in place to ensure that the quality of services provided by the hospital are evaluated on an annual basis and discussed with relevant stakeholders. Audits are undertaken as above.

There are clear arrangements for monitoring the quality of clinical care that include the following indicators:

- Unplanned returns to theatre
- Peri-operative deaths
- Unplanned re-admissions to hospital
- Unplanned transfers to other hospitals
- Adverse clinical incidents
- Post-operative infection rates for the hospital

The hospital does not provide overnight beds however arrangements are in place to access inpatient beds if required.

The establishment has an incident policy and procedure in place which includes reporting arrangements to RQIA.

The inspector reviewed incident management and found that incidents were documented, fully investigated and had outcomes recorded. However it was noted that some incidents had not been reported to RQIA in line with the legislation. Following discussion, the registered manager informed the inspector that the incidents had not been reported due to a misunderstanding of the incident guidance. A requirement was made to retrospectively report these incidents to RQIA and ensure any future incidents are reported within the agreed timescales. The inspector advised the registered manager to contact RQIA if she was unsure regarding the reporting of any incident for further guidance.

Audits of incidents are undertaken quarterly and learning outcomes are identified and disseminated throughout the organisation.

The registered manager confirmed that no research is currently being undertaken within the hospital. The registered manager also confirmed before any research involving patients would be considered a research proposal would be prepared and approval obtained from the appropriate Research Ethics Committee (REC).

Evidenced by:

Review of policies and procedures
Review of training records/competency records
Discussion with registered provider/manager
Review of monitoring reports
Review of audits
Review of incident management
Review of research arrangements

STANDARD 16	
Management and Control of Operations:	**Management systems and arrangements are in place that ensure the delivery of quality treatment and care.**

There is a defined organisational and management structure that identifies the lines of accountability, specific roles and details responsibilities for all areas of the service.

The establishment has a policy and procedure in place to ensure that RQIA is notified if the registered manager is absence for more than 28 days. The policy includes the interim management arrangements for the establishment.

Review of the training records and discussion with the registered manager confirmed that she undertakes training relevant to her role and responsibilities within the organisation.

The inspector reviewed the establishment's Patient Guide and Statement of Purpose and found them to be in line with the legislation.

The inspector confirmed that appropriate meals are provided in line with the assessed needs of the patients. Day case patients are offered refreshments prior to discharge.

The registered person has arrangements in place to confirm that staff supplied by an agency have been recruited and checked in accordance with recruitment procedures used by the establishment. There is an induction programme in place for agency staff. The inspector reviewed completed agency inductions as part of the inspection process.

There is a written policy on "Whistle Blowing" and written procedures that identify to whom staff report concerns about poor practice and the support mechanisms available to those staff.

The inspector discussed the insurance arrangements within the establishment and confirmed current insurance policies were in place. The certificates of registration and insurance were clearly displayed in the premises.

Evidenced by:

Review of policies and procedures
Review of training records
Review of Patient Guide
Review of Statement of Purpose
Review of arrangements for meals
Review of insurance arrangements

STANDARD 31	
Resuscitation:	**Resuscitation equipment is readily accessible and resuscitation is carried out by trained competent staff and in line with the Statement of Purpose.**

There is a written resuscitation policy in place which was found to be in line with the Resuscitation Council (UK) guidelines.

Staff had received basic life support training and updates. All theatre staff have received advanced life support training. There is always at least one staff member with advanced life support training on duty at all times.

The inspector discussed arrangements regarding patients with a "Do Not Resuscitate" (DNR) order in place. As the hospital provides day surgery only the registered manager confirmed that patients who would have a DNR order in place would not meet the criteria for the hospital and therefore would not be admitted.

There is a range of resuscitation equipment in place in the recovery department and basis resuscitation equipment is also retained in the first floor treatment room.

Equipment for resuscitating patients includes:

- A charged defibrillator and ECG monitor
- Portable oxygen with appropriate valves, mask, metering and delivery system
- First line resuscitation medication
- Equipment for maintaining and securing the airway of a patient
- Equipment to insert and maintain intravenous infusions
- Latex free alternative equipment

Resuscitation equipment is checked and restocked to ensure all equipment remains in working order and suitable for use at all times. A record of all equipment and drugs is attached to the resuscitation trolley and a written record is retained of the daily checks.

The inspector observed that medication to be used in the event of a medical emergency was included on the resuscitation trolley however the drugs were not included on the check list. The inspector also observed that the names and size of fluids were included on the list, however the number of bags stored was not included. It is recommended that the list of emergency medication is expanded to include the drugs used in a medical emergency and the number of each type of fluid to be retained on the trolley.

Resuscitation equipment is cleaned and decontaminated following use.

Evidenced by:

Review of resuscitation policy and procedure
Review of records of resuscitation equipment and checks
Review of resuscitation equipment
Review of resuscitation training

STANDARD 32	
Surgery:	**There are arrangements in place to support the provision of safe and effective surgical practices.**

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

The nursing staff contact patients prior to admission and undertake a pre-admission consultation on the phone.

The inspector met with the theatre manager to discuss staffing levels. The theatres were found to have adequate staffing levels to meet the individual needs of the patients undergoing surgery.

There is an identified senior member of nursing staff, with theatre experience, in charge of the operating theatre at all times.

The inspector reviewed the register which is maintained for all surgical procedures undertaken in the hospital and found it contained all of the information required by legislation.

On discussion staff confirmed that the surgical checklist based on the World Health Organisation (WHO) model is used in the hospital. The inspector reviewed completed surgical checklists within the patients' care records.

Prior to surgery, the inspector confirmed, that patients receive verbal and written pre-operative information on:

- Fasting
- Taking of existing medication
- Arrangements for escort to and from theatre

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

The inspector was informed the medical practitioner is present throughout the operation and the anaesthetist is present onsite until the patient has recovered from the immediate effects of the anaesthetic.

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.

Review of the patient care records and discussion with the registered manager confirmed that the surgical checklist based on the World Health Organisation (WHO) model is used in the hospital. The inspector discussed intra-operative fluid management, the identification of the theatre team leader, the completion of the WHO checklist and roles and responsibilities of the theatre team with the registered manager. The registered manager displayed a good understanding of the topics discussed.

The inspector recommended identifying the name of the team leader on the off duty to ensure that a permanent record is retained.

The hospital has a discharge criterion in place from the recovery area to home.

Patients are provided with written post-operative instructions relevant to their individual procedure which includes:

- Pain relief
- Bleeding
- Care of the post-operative site
- The potential effects of anaesthesia

Equipment, installations and facilities are in place to provide the services outlined in the hospital's Statement of Purpose. There are systems in place to ensure that theatre equipment is maintained and decontaminated in line with the manufacturers' guidelines.

A review of theatre practices is due to be undertaken by a separate team of RQIA inspectors on 14 August 2014. A copy of the review report will be forwarded to the hospital and made available on the RQIA website.

Evidenced by:

Review of theatre policies and procedures
Review of surgical register of operations
Discussion with theatre manager
Discussion with staff
Review of facilities
Review of service records for equipment

7.0 Other Areas Examined

7.1 Laser Warning Signs

On review of the environment the inspector observed that an illuminated laser warning sign was displayed in corridor outside theatre and a laser warning sign was also displayed on the door leading to the theatre. The registered manager informed the inspector that the signs were installed but lasers were never used in theatres. As refurbishment is currently ongoing within the clinic the registered manager agreed to remove the signage. A recommendation was made in this regard.

7.2 Management of Records

The inspector reviewed the management of records policy. The timescale for the retention of records was updated during the inspection by the practice manager to comply with the current legislation.

8.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Sheila Jordan, registered manager and Mrs Kelly Buckley, practice manager as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider / manager is required to record comments on the Quality Improvement Plan.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Enquiries relating to this report should be addressed to:

Jo Browne
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Announced Inspection

Fitzwilliam Clinic

30 July 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Ms Sheila Jordan, registered manager and Mrs Kelly Buckley, practice manager, during the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

STATUTORY REQUIREMENT

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Independent Health Care Regulations (Northern Ireland) 2005 and The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011.

NO.	REGULATION REFERENCE	REQUIREMENT	NUMBER OF TIMES STATED	DETAILS OF ACTION TAKEN BY REGISTERED PERSON(S)	TIMESCALE
1	28 (1)	The registered manager must ensure that all identified notifiable incidents are retrospectively reported to RQIA and ensure any future incidents are reported within the agreed timescales. **Ref: Standard 9**	One	Actioned immediately. S Jordan	Immediately and ongoing

RECOMMENDATIONS

These recommendations are based on the DHSSPS draft Independent Health Care Minimum Standards for Hospitals and Clinics, research or recognised sources. They promote current good practice and if adopted by the registered person/manager may enhance service, quality and delivery.

NO.	MINIMUM STANDARD REFERENCE	RECOMMENDATIONS	NUMBER OF TIMES STATED	DETAILS OF ACTION TAKEN BY REGISTERED PERSON(S)	TIMESCALE
1	31.10	The registered manager should ensure that the list of emergency medication is expanded to include the drugs used in a medical emergency and the number of each type of fluid to be retained on the resuscitation trolley. **Ref: Standard 31**	One	Actioned. immediately.	Immediately and ongoing
2	32.3	The registered manager should ensure that the name of the team leader is identified on the off duty to ensure that a permanent record is retained. **Ref: Standard 32**	One	Actioned. immediately	Immediately and ongoing
3	48.16	The registered manager should ensure that the illuminated laser warning sign and the laser warning sign on the door leading to the theatre are removed. **Ref: Standard 48**	One	Actioned	One month

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person and return to independent.healthcare@rqia.org.uk

Name of Registered Manager Completing QIP	SHEILA JORDAN
Name of Responsible Person / Identified Responsible Person Approving QIP	STEPHEN SINCLAIR

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	✓		1/10/14
Further information requested from provider			

The Regulation and Quality Improvement Authority

Pre-Inspection Self-Assessment Independent Hospital

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Inspection No:	**17481**

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
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1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect independent health care establishments. A minimum of one inspection per year is required.

The aim of inspection is to examine the policies, procedures, practices and monitoring arrangements for the provision of an independent hospital, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Independent Health Care Regulations (Northern Ireland) 2005
- The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011
- The Department of Health, Social Services and Public Safety's (DHSSPS) draft Independent Health Care Minimum Standards for Hospitals and Clinics

Other published standards which guide best practice may also be referenced during the inspection process.

2.0 Self-Assessment

Committed to a culture of learning, RQIA has developed an approach which uses self-assessment.

Where asked in the self-assessment you are required to indicate a yes or no response. You are also asked to provide a brief narrative in the "text box" where applicable.

Following completion of the self-assessment, please return to RQIA by the date specified.

The self-assessment will be appended to the report and made available to the public. No amendments will be made by RQIA to your self-assessment response.

3.0 Self-Assessment Tool

Management of Operations

	YES	NO
Has any structural change been made to the premises since the previous inspection?		✓
Have any changes been made to the management structure of the hospital since the previous inspection?		✓
Yes, please comment		

Policies and Procedures

	YES	NO
Does the hospital have a policy and procedure manual in place which is reviewed at least every 3 years or as changes occur?	✓	
Are the policies and procedures for all operational areas in line with legislation and best practice guidelines?	✓	
Do all policies and procedures contain the date of issue, date of review and version control?	✓	
Are all policies and procedures ratified by the registered person?	✓	
No, please comment		

Records Management

	YES	NO
Does the hospital have a policy and procedure in place for the creation, storage, transfer, retention and disposal of and access to records in line with the legislation?	✓	
Are care records maintained for each individual patient?	✓	
Do the care records reflect the patient pathway from referral to discharge?	✓	
Are arrangements in place to securely store patient care records?	✓	
No, please comment		

Patient Partnerships

	YES	NO
Does the hospital have systems in place to obtain the views of patients regarding the quality of treatment, care and information provided?	✓	
Does the hospital make available a summary report of patient feedback to patients and other interested parties?	✓	
No, please comment		

Resuscitation

	YES	NO
Does the hospital have a resuscitation policy and procedure in place which is in line with the Resuscitation Council (UK) guidance?	✓	
Is resuscitation equipment readily accessible in all clinical areas?	✓	
Are arrangements in place to ensure resuscitation equipment is checked regularly and restocked to ensure all equipment remains in working order and suitable for use at all times?	✓	
Is there at least one person with advance life support training on duty at all times?	✓	
Where children are admitted for treatment, is there at least one person with paediatric advanced life support training on duty at all times?	N/A	
No, please comment		

Safeguarding

	YES	NO
Does the hospital have a protection of vulnerable adults policy and procedure in place which is in line with the legislation and regional guidance?	✓	
Does the hospital have a safeguarding children policy and procedure in place which is in line with the legislation and regional guidance?	N/A	
Does the hospital have a whistle-blowing policy and procedure in place?	✓	
No, please comment		

Complaints

	YES	NO
Does the hospital have a complaints policy and procedure in place which is in line with the legislation and the DHSSPS guidance on complaints handling in regulated establishments and agencies April 2009?	✓	
Are all complaints documented, fully investigated and have outcomes recorded in line with the legislation and the hospital's complaints policy and procedure?	✓	
No, please comment		

Incidents

	YES	NO
Does the hospital have an incident policy and procedure in place which complies with the legislation and RQIA guidance?	✓	
Are all incidents reported, documented, fully investigated and have outcomes recorded in line the legislation, RQIA guidance and the hospital's policy and procedure?	✓	
No, please comment		

Infection Prevention and Control

	YES	NO
Does the hospital have an infection prevention and control policy and procedure in place?	✓	
Are appropriate arrangements in place to decontaminate equipment between patients?	✓	
Does the hospital use single use surgical instruments?	✓	
Does the hospital have appropriate service level agreements in place for the sterilisation of surgical equipment?	✓	
No, please comment		

Recruitment of staff

	YES	NO
Does the hospital have a recruitment and selection policy and procedure in place?	✓	
Is all information outlined in Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005 retained and available for inspection?	✓	
Have all staff had an enhanced AccessNI disclosure undertaken, prior to commencing employment?	✓	
No, please comment		

Staffing

	YES	NO
Is there appropriate numbers of suitably qualified, skilled and experienced staff on duty to meet the assessed needs of the patients and the operational requirements of the hospital?	✓	
No, please comment		

Mandatory Training

	YES	NO
Are arrangements in place for all new staff to participate in an induction programme relevant to their roles and responsibilities?	✓	
Are arrangements in place for staff to access continuing professional development opportunities in line with the requirements of their professional bodies?	✓	
Are training records available which confirm that the following mandatory training has been undertaken:		
	YES	**NO**
Moving and Handling – annually	✓	
Protection of vulnerable adults – every 3 years	✓	
Safeguarding children (where services are provided to children) – every 3 years	N/A	
Infection prevention and control training – annually	✓	

Fire safety – annually	✓	
Basic adult life support - annually	✓	
Basic paediatric life support (where services are provided to children) - annually	NA	
If No, please comment		

Appraisal

	YES	NO
Does the hospital have an appraisal policy and procedure in place?	✓	
Are systems in place to provide recorded annual appraisals for staff?	✓	
No, please comment		

Medical Practitioners, Nurses, Social Workers & Allied Health Professionals

	YES	NO
Are systems in place to ensure medical, nursing staff, social workers and allied health professionals have a current registration with their relevant professional bodies?	✓	
Are policies and procedures in place to grant, review and withdraw practising privilege agreements for medical practitioners?	✓	
Are practising privileges agreements in place for all medical practitioners? (where applicable)	✓	
Are systems in place to ensure that medical practitioners have up to date professional indemnity insurance?	✓	
Are systems in place to ensure that medical practitioners have an annual appraisal undertaken with a trained medical appraiser?	✓	
Are arrangements in place to ensure medical practitioners have a responsible officer?	✓	
No, please comment		

Surgical Services

	YES	NO
Are there suitable arrangements in place to provide appropriate pre-operative, peri-operative and post-operative care for patients?	✓	
Is an holistic assessment of patients care needs, using validated tools, carried out?	✓	
Are patient centred care plans developed and implemented for each patient and reviewed as changes occur?	✓	
Are contemporaneous medical records retained for each individual patient?	✓	
Does the hospital have a theatre manual in place?	✓	
Is there a register of operations retained that contains all of the information outlined in the legislation?	✓	
Does the hospital use the World Health Organisation (WHO) surgical checklist for each operation undertaken?	✓	
Does the hospital have systems in place for surgical pause?	✓	
Does the hospital provide endoscopy services?		✓
Are there suitable arrangements in place for the provision of endoscopy services in line with best practice guidance? (where applicable)		N/A
Are systems in place to provide discharge information to patient's general practitioners and others involved in the patient's ongoing care?	✓	
Are arrangements in place for the collection, labelling, storage, preservation, transport and administration of specimens?	✓	
No, please comment		

4.0 Declaration

To be signed by the registered provider or registered manager for the establishment.

I hereby confirm that the information provided above is, to the best of my knowledge, accurately completed.

Name	Signature	Designation	Date
SHEILA JORDAN	S Jordan	registered nurse	14/7/14