Follow Up Inspection Report
01 February 2017

Fitzwilliam Clinic

Type of service: Independent Hospital (IH) - IH-Day cases only
Address: 70-72 Lisburn Road, Belfast, BT9 6AF
Tel no: 028 9032 3888
Inspectors: Emily Campbell and Winnie Maguire

1.0 Summary

An announced follow-up inspection of Fitzwilliam Clinic took place on 1 February 2017 from 9:50 to 16:10.

The focus of the follow-up inspection was to ascertain the progress made to address the requirements and recommendations made as a result of the announced care inspection carried out on 24 October 2016.

Review of documentation and discussion with Ms Sheila Jordan, registered manager, evidenced that there has been substantial progress made in order to address the four requirements and 17 recommendations made. Three of the four requirement made have been addressed. One requirement regarding a Private Doctor's appraisal has not been addressed and was stated for the second time.

Nine of the 17 recommendations have been addressed, five partially addressed and three not addressed. Of the five partially addressed recommendations made, one requirement was made to discuss the infection prevention and control (IPC) advisor's report at the next Medical Advisory Committee (MAC) meeting. Five recommendations were made in relation to further development of the safeguarding policy, auditing of completion of consent forms and Venous Thromboembolism (VTE) risk assessment forms, ratifying the VTE risk assessment protocol and submission of the minutes of the next MAC meeting. Of the three recommendations not addressed, two requirements were made in relation to monitoring staff training and development and advance life support (ALS) training. One recommendation in relation to patient satisfaction surveys was stated for the second time. A recommendation was also made that the new arrangements put in place in relation to the Methylene Blue Dye are discussed with the IPC advisor.

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) The 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	7

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 24 October 2016.

2.0 Service details

Registered organisation/registered person: Fitzwilliam Partnership Mr James Small Mr Andrew Kennedy Mr Stephen Sinclair	**Registered manager:** Ms Sheila Jordan
Person in charge of the establishment at the time of inspection: Ms Sheila Jordan	**Date manager registered:** 13 January 2014
Categories of care: Independent Hospital (IH): AH(DS) - Acute Hospital (Day Surgery) PD - Private Doctor Following submission of an application of variation the following categories of care were removed from the register on 17 February 2017: PT(L) - Prescribed Technologies, Laser PT(IL) - Prescribed Technologies, Intense Light Source	

3.0 Methods/processes

Prior to inspection we analysed the QIP submitted by Ms Jordan in respect of the inspection carried out on 24 October 2016.

During the inspection the inspectors met with Ms Jordan and a tour of the premises was undertaken.

The following records were examined during the inspection:

- 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

- management and governance arrangements.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 24 October 2016

The most recent inspection of the establishment was an announced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 24 October 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 18 (3) **Stated:** First time	The registered provider must submit evidence of the Private Doctor's current appraisal to RQIA.	**Not Met**
	Action taken as confirmed during the inspection: Ms Jordan confirmed that the private doctor had arranged his appraisal which is also being done in conjunction with his revalidation. This has been delayed due to the fact that the appraiser has to assess the private doctor's skills in surgery. The private doctor has informed Ms Jordan that the appraisal will be completed by 18 March 2017. It was agreed that documentary evidence of the Private Doctor's appraisal will be submitted to RQIA after 18 March 2017. This requirement has not been addressed and was stated for the second time.	

Requirement 2 **Ref:** Regulation 15 (2) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Review of the emergency medication and equipment evidenced that a razor had been provided and the nasopharyngeal airway and 20ml syringes had been replaced. Discussion with Ms Jordan and review of documentation evidenced that a more robust system has been established for checking the medications and equipment. It was suggested that the checking procedure is further developed to provide a list of each individual medicine/piece of equipment that is signed off against each month.	
Requirement 3 **Ref:** Regulation 15 (7) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Discussion with Ms Jordan and observations made and evidenced that this requirement has been addressed, with the exception of the provision of a wipeable keyboard. Ms Jordan advised this had been ordered and confirmed by email on 2 February 2017 that it had been received. A recommendation was made during this inspection that the new arrangements put in place in relation to the Methylene Blue Dye are discussed with the infection prevention and control (IPC) advisor to confirm they are satisfactory.	

Requirement 4 **Ref:** Regulation 9 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: The statement of purpose and patient guide had been updated as required. The date these documents had been updated were not reflected on the documents; however, this was addressed during the inspection.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 13.3 **Stated:** First time	Records of induction should be completed and retained in personnel files of any new staff recruited.	**Met**
	Action taken as confirmed during the inspection: No new staff have been recruited since the previous inspection. However, Ms Jordan provided assurance that induction records would be completed and retained in staff files when new staff are recruited.	
Recommendation 2 **Ref**: Standard 13.9 **Stated:** First time	A system should be established to ensure that staff, including bank staff, receive appraisal on an annual basis.	**Met**
	Action taken as confirmed during the inspection: Ms Jordan confirmed that all permanent nursing staff and three of the five bank nursing staff have received appraisal and dates have been arranged for the remaining two bank nursing staff in this regard. Ms Jordan advised by email on 14 February 2017 that the fourth bank nurse has received appraisal and the fifth bank nurse will receive appraisal on their return from leave. A new practice manager is due to commence work in the next few weeks and Ms Jordan advised that an appraisal programme for administration staff will be established after the practice manager has had an opportunity to assess staff.	

Recommendation 3 **Ref**: Standard 13.4 **Stated:** First time	A system should be established for recording and monitoring all aspects of staff ongoing professional development, including specialist qualifications and training.	**Not Met**
	Action taken as confirmed during the inspection: Discussion with Ms Jordan confirmed that this recommendation has not been addressed. A requirement was made in this regard.	
Recommendation 4 **Ref**: Standard 14.2 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: As discussed previously, Ms Jordan confirmed that no new staff had been recruited since the previous inspection. However, assurance was provided that 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, would be obtained in respect of any new staff recruited.	
Recommendation 5 **Ref**: Standard 14.3 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: No new staff have been recruited since the previous inspection. Assurance was provided by Ms Jordan that information pertaining to enhanced AccessNI checks would be recorded in keeping with AccessNI's code of practice	

Recommendation 6 **Ref**: Standard 14.1 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Ms Jordan confirmed that the recruitment policy had not yet been further developed. However, the revised policy was submitted to RQIA by email on 14 February 2017. The policy was reflective of best practice guidance. It was suggested that the information to be obtained prior to staff commencing employment contains more specific detail.	
Recommendation 7 **Ref**: Standard 32.1 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Review of six patient records, including patients who received surgery using local anaesthetic, evidenced that the surgical safety checklist had been completed. The surgical safety checklists had been included in the hospital's clinical record audit programme.	

Recommendation 8 **Ref**: Standard 3 **Stated:** First time	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.	**Partially Met**
	Action taken as confirmed during the inspection: The adult safeguarding policy had not been further developed at the time of the inspection; however, a revised policy was submitted to RQIA by email on 14 February 2017. A recommendation was made that the policy is further developed to include the types and indicators of abuse, that safeguarding will be a topic covered at induction and documentation arrangements. A copy of the new regional guidance was available to staff. Ms Jordan confirmed that staff had completed update training in safeguarding adults at risk of harm. However, review of the training certificates indicated this training was in relation to vulnerable adults and it was not clear if the new regional guidance had been included. Ms Jordan agreed to clarify this and confirmation was provided by email on 2 February 2017 that the training did reflect the new regional guidance and that training certificates had been re-issued to reflect the correct course content. Ms Jordan confirmed that safeguarding training would be a topic covered at induction for any new staff recruited.	

Recommendation 9 **Ref**: Standard 31.7 **Stated:** First time	Ensure there is at least one person on duty at all times with certified advanced life support (ALS) training. Records should be retained.	**Not Met**
	Action taken as confirmed during the inspection: Modified ALS training has been booked for 25 February 2017. Ms Jordan confirmed during the inspection that she would contact the training provider to arrange for all permanent nursing staff to receive training at ALS level. This recommendation has not been addressed and was stated as a requirement.	
Recommendation 10 **Ref**: Standard 20 **Stated:** First time	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.	**Partially Met**
	Action taken as confirmed during the inspection: Discussion with Ms Jordan and review of documentation confirmed that an action plan had been devised to address areas identified for corrective actions identified by the IPC advisor; however, it did not include some governance and audit actions. The corrective actions action plan only identified the actions to be taken, who is responsible and then the date of completion. It did not identify an achievement date to be aimed for and a number of actions still had not been addressed. A requirement made that the IPC advisor's report of 22 July 2016 is brought to the attention of the Medical Advisory Committee (MAC) on Tuesday 21 February 2017 and an implementation strategy devised. It was stressed that in order to implement the recommendations by the independent IPC audit, considerable time and effort will need to be afforded to address this matter.	

Recommendation 11 **Ref**: Standard 6.7 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Review of six patient records evidenced that doctor's consultation records had been amalgamated with the hospital record.	
Recommendation 12 **Ref**: Standard 2 **Stated:** First time	Consent forms should be fully completed and surgeon's signatures should be legible and written in full.	**Partially Met**
	Action taken as confirmed during the inspection: Six patient records reviewed evidenced that consent forms had been completed. However, in one record the consultant surgeon had identified the risks only, what was explained and the intended benefits were not completed. A recommendation was made that completion of consent forms should be included in the records audit. Any issues of repeated non-compliance that are not addressed by individual surgeons should be brought to the attention of the MAC.	
Recommendation 13 **Ref**: Standard 32.1 **Stated:** First time	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.	**Partially Met**

	Action taken as confirmed during the inspection: Review of six patient's records evidenced that a VTE risk assessment had been completed. These had been completed by nurses and then countersigned by the surgeon. The regional VTE assessment is in use. The VTE risk assessment protocol had been updated to reflect that the assessment should be completed by the consultant surgeon; this was a decision taken by Ms Jordan following discussion with some of the senior consultants but it was not ratified by the Clinic Board Group/MAC. A recommendation was made that the revised protocol should be ratified by the Clinic Board Group/MAC at the next MAC meeting scheduled for 21 February 2016. A recommendation was also made that VTE completion should be audited and any issues identified should be brought to the attention of the MAC.	
Recommendation 14 **Ref**: Standard 5 **Stated:** First time	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.	**Not Met**
	Action taken as confirmed during the inspection: This recommendation has not been addressed and was stated for the second time. Discussion with Ms Jordan identified that she did not fully understand this recommendation and further clarification was provided during the inspection.	

Recommendation 15 **Ref**: Standard 30.6 **Stated:** First time	The hospital Board medical advisory committee meetings should be re-instated and held at least every three months.	**Partially Met**
	Action taken as confirmed during the inspection: There have been no MAC meetings since the previous inspection; however, Ms Jordan stated that arrangements had been made for meetings to be held every month on the third Tuesday of each month. The first meeting is scheduled to be held on 21 February 2017. A recommendation was made that the minutes of the meeting on 21 February 2017 are to be forwarded to RQIA.	
Recommendation 16 **Ref**: Standard 7.8 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Ms Jordan confirmed that there have been no complaints received since the previous inspection; however assurances were provided that more detailed records would be retained in relation to complaints investigations.	
Recommendation 17 **Ref**: Standard 16 **Stated:** First time	An application of variation to de-register the laser and IPL categories of care should be submitted to RQIA.	**Met**
	Action taken as confirmed during the inspection: An application for variation had not been submitted to RQIA. However, this was subsequently received by RQIA on 2 February 2017.	

Areas for improvement

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

The arrangements put in place in relation to the Methylene Blue Dye should be discussed with the infection prevention and control (IPC) advisor to confirm they are satisfactory.

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

The adult safeguarding policy should be further developed.

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

The IPC advisor's report of 22 July 2016 should be brought to the attention of the MAC on Tuesday 21 February 2017 and an implementation strategy devised.

Completion of consent forms should be included in the records audit. Any issues of repeated non-compliance that are not addressed by individual surgeons should to be brought to the attention of the MAC.

The revised VTE risk assessment protocol should be ratified by the Clinic Board Group/MAC at the next MAC meeting scheduled for 21 February 2016.

VTE completion should be audited and any issues identified should be brought to the attention of the MAC.

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

The minutes of the MAC meeting on 21 February 2017 should be forwarded to RQIA.

Number of requirements	4	**Number of recommendations**	7

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.

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:** Second time **To be completed by:** 31 March 2017	The registered provider must submit evidence of the Private Doctor's current appraisal to RQIA.
	Response by registered provider detailing the actions taken: The private Doctor's current appraisal is complete. A copy of appraisal has been attached.
Requirement 2 **Ref:** Regulation 21 (3) Schedule 3 Part II (9) **Stated:** First time **To be completed by:** 1 April 2017	The registered provider must ensure that a system is 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 computerised system is now being used to record and monitor staff training and ongoing development.
Requirement 3 **Ref:** Regulation 18 (1) **Stated:** First time **To be completed by:** 1 May 2017	The registered provider must 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: To follow the modified ALS course we have now arranged for the three senior nurses to do the ALS course. This will ensure that there will be a member of staff on duty at all times with ALS training. This is a 2 day course which has been arranged , will be completed by 28th April 2017.
Requirement 4 **Ref:** Regulation 15 (7) **Stated:** First time **To be completed by:** 21 February 2017	The registered provider must ensure that the infection prevention and control (IPC) advisor's report of 22 July 2016 should be brought to the attention of the Medical Advisory Committee (MAC) on Tuesday 21 February 2017. An implementation strategy to address the IPC advisor's recommendations should be devised.
	Response by registered provider detailing the actions taken: There was a MAC meeting on Monday 6th March. The IPC advisor's report was on the agenda and dissussed. There will be an action plan devised to follow up on the next IPC audit, which will be done in April.

Recommendations	
Recommendation 1 **Ref**: Standard 20.5 **Stated:** First time **To be completed by:** 1 March 2017	The arrangements put in place in relation to the Methylene Blue Dye are discussed with the infection prevention and control (IPC) advisor to confirm they are satisfactory.
	Response by registered provider detailing the actions taken: Following discussion with our IPC advisor, he has advised us to use Methylene Blue Dye as a single use item. This been adhered to immediately as we now do not have a delivery issue.
Recommendation 2 **Ref**: Standard 3.1 **Stated:** First time **To be completed by:** 1 May 2017	The adult safeguarding policy should be further developed to include the types and indicators of abuse, that safeguarding will be a topic covered at induction and documentation arrangements.
	Response by registered provider detailing the actions taken: The adult safeguarding policy will be now included at the induction of any new staff employed. The policy now includes types and indicators of abuse
Recommendation 3 **Ref**: Standard 9.3 **Stated:** First time **To be completed by:** 1 April 2017	Completion of consent forms should be included in the records audit. Any issues of repeated non-compliance that are not addressed by individual surgeons should be brought to the attention of the Medical Advisory Committee (MAC).
	Response by registered provider detailing the actions taken: We have now recommenced regular MAC meetings. Outcome of the audits will be a regular item on the agenda.
Recommendation 4 **Ref**: Standard 30.5 **Stated:** First time **To be completed by:** 21 February 2016	The revised Venous Thromboembolism (VTE) risk assessment protocol should be ratified by the Clinic Board Group/MAC at the next MAC meeting scheduled for 21 February 2016.
	Response by registered provider detailing the actions taken: Revised VTE risk assessment was an item on agenda at our last MAC meeting dated Monday 6th March and has been ratified by the board.
Recommendation 5 **Ref**: Standard 9.3 **Stated:** First time **To be completed by:** 1 April 2017	Venous Thromboembolism (VTE) completion should be audited and any issues identified should be brought to the attention of the MAC.
	Response by registered provider detailing the actions taken: There are ongoing audits including VTE completion. Any issues will be discussed at the monthly MAC meeting.

Recommendation 6 **Ref**: Standard 5 **Stated:** Second time **To be completed by:** 1 May 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: The patient satisfaction survey now has individual results of all the questions.
Recommendation 7 **Ref**: Standard 30.2 **Stated:** First time **To be completed by:** 21 March 2017	The minutes of the MAC meeting on 21 February 2017 should be forwarded to RQIA.
	Response by registered provider detailing the actions taken: I have attached minutes of our MAC meeting dated 6th March 2017 (previously arranged for 21st Feb). I have deleted minutes which are not relevant to your requests as information confidential. ,

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

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

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews