Unannounced Inspection Report
2 December 2019

Fitzwilliam Clinic

Type of Service: Independent Hospital – Surgical Services
Address: 70-72 Lisburn Road, Belfast, BT9 6AF
Tel No: 028 9032 3888

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Membership of the Inspection Team

Jo Browne	Senior Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Dr Gerry Lynch	Senior Medical Advisor Regulation and Quality Improvement Authority
Thomas Hughes	Inspector, Hospital Programmes Team Regulation and Quality Improvement Authority
Norma Munn	Inspector, Independent Healthcare Team Regulation and Quality Improvement Authority
Paul Nixon	Inspector, Medicines Management Team Regulation and Quality Improvement Authority
Raymond Sayers	Inspector, Premises Team Regulation and Quality Improvement Authority

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of the Hospital

Fitzwilliam Clinic is registered to accommodate day surgery patients. There no overnight beds provided in this hospital. The hospital provides a range of surgical, cosmetic and outpatient services for adults. The hospital is also registered for doctors working in wholly private practice. The hospital has one theatre and a small 2 bedded recovery unit.

3.0 Service details

Organisation/Registered Provider: Fitzwilliam Clinic **Responsible Individual(s):** Mr James Small Mr Stephen Sinclair Mr Andrew Kennedy	**Registered Manager:** Ms Denise Shields (Acting)
Person in charge at the time of inspection: Ms. Denise Shields	**Date manager registered:** Application Pending
Categories of care: Independent Hospital (IH) – AH(DS) - Acute Hospital (Day Surgery) PD - Private Doctor	

4.0 Inspection summary

We undertook an unannounced inspection to Fitzwilliam Clinic over one day on 2 December 2019 from 09:00 hours to 18:30 hours.

This inspection was underpinned by The Health and Personal Social Services (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 and the Department of Health (DOH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

We employed a multidisciplinary inspection methodology during this inspection. The multi-disciplinary inspection team examined a number of aspects of the hospital, from front line care and practices, to management and oversight of governance. The inspection team met with various staff groups spoke with several patients, observed care practice and reviewed relevant records and documentation to support the organisational governance and assurance systems.

Patients informed us they were happy with their care and spoke positively regarding their experiences and interactions with all staff. Patients felt safe, secure and well informed about the care they were receiving. We observed staff treating patients and/or their representatives with dignity, staff were respectful of patients' right to privacy.

No immediate concerns were identified in relation to delivery of front line patient care. We noted multiple areas of strength, particularly in relation to the delivery of front-line care.

Examples of good practice were evidenced in all four domains. The four domains are outlined in section 1.0 of this report. These related to clinical and organisational governance; staffing; staff appraisal and supervision; the provision of surgical services; the environment; management of the patients' care pathway; communication; practising privileges arrangements; and engagement to enhance the patients' experience.

Areas requiring improvement were identified in relation to infection prevention and control (IPC); environmental estate; safeguarding; medicines management; and dealing with medical emergencies.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	4

One area for improvement against the regulations was identified in relation to the weekly fire detection and alarm system test activations and the fire risk assessment.

One area for improvement was identified against a regulation in relation to the environmental premises. Four areas for improvement against the standards were identified in relation to relation to infection prevention and control (IPC); safeguarding; medicines management; and dealing with medical emergencies.

On 2 December 2019, we provided feedback to Ms Denise Shields, Acting Manager (RM) and team regarding the inspection findings. During this meeting, we discussed the hospital's strengths and the areas requiring improvement identified during our inspection.

We discussed the actions, which are required within the Quality Improvement Plan (QIP). The timescales for completion of these actions commence from the date of our inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 19 February 2019.

5.0 How we inspect

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

- notifiable events prior to and since the previous inspection;
- registration status of the establishment;
- written and verbal communication received since the previous inspection;
- the previous inspection reports; and
- QIPs returned following the previous inspections.

During our inspection, we spoke with patients and distributed questionnaires to patients. We received three completed patient questionnaires, which were analysed following the inspection. We also invited staff to complete an electronic questionnaire during the inspection. We did not receive any completed staff questionnaires during or following the inspection.

Posters informing patients, staff and visitors of our inspection were displayed while our inspection was in progress.

During our inspection, we met with the following staff: Ms Shields (Acting Manager), medical staff; nursing staff; healthcare assistants; reception staff and the nominated hospital's Estates and Facilities Manager.

We inspected the reception area, waiting areas, consultation rooms, the main theatre and adjoining recovery area, treatment rooms, storerooms and patient toilet areas.

During the inspection a sample of records were examined in relation to each of these areas inspected.

We provided detailed feedback on our inspection findings as described in section 4.1.

6.0 The inspection

6.1 Review of areas for improvement from the last care inspection dated 19 February 2019

The previous inspection of the hospital was an announced care inspection undertaken on 19 February 2019.

6.2 Review of areas for improvement from the most recent inspections dated 28 to 29 November 2017, 20 January 2017 and 19 January 2016 respectively

Areas for improvement from the last care inspection on 19 February 2019		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Minimum Care Standards for Independent Healthcare Establishments (2014)		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 26 **Stated:** First time	The registered persons shall ensure that six monthly unannounced visits by one of the registered persons or their nominated representative, as outlined in Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended, are carried out. Written reports of the unannounced visits should be available for inspection. Ref: 6.7	**Met**
	Action taken as confirmed during the inspection: We confirmed that one of the registered persons had undertaken a visit on 18 June 2019 in line with Regulation 26 and produced a report. The report was found to be robust and there was evidence of the report being reviewed by the Medical Advisory Committee (MAC).	
Area for improvement 2 **Ref**: Standard 9.4 **Stated:** Second time	The registered person shall generate an action plan for each monthly clinical record audit and record actions taken to improve compliance, including the names of staff that were spoken with. Ref: 6.2 and 6.7	**Met**
	Action taken as confirmed during the inspection: We found that audits reviewed had action plans in place in improve compliance.	

Area for improvement 3 **Ref**: Standard 3.1 **Stated:** First time	The registered person shall ensure that a safeguarding children's policy is developed in keeping with regional guidance, this should then be shared with staff. Ref: 6.4	**Met**
	Action taken as confirmed during the inspection: We found that the safeguarding children's policy has been developed in keeping with regional guidance and we evidenced that it was shared with hospital staff.	

6.3 Inspection findings

6.4 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

6.4.1 Clinical and organisational governance

We examined various aspects of the governance systems in place.

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.

We reviewed a sample of records and minutes of meetings and discussed the hospital's governance arrangements and managerial oversight with a number of staff. This included meeting with Mr Sinclair, Responsible Individual, Ms Denise Shields, Acting Manager and the theatre manager.

We found that policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, dated and systematically reviewed on a three yearly basis. Staff who we spoke with, were aware of the policies and how to access them.

6.4.2 Medical governance and Medical Advisory Committee

We found that systems were in place to ensure that the quality of services provided by the hospital. The hospital has a defined clinical governance structure in place with regular clinical meetings involving all areas of the hospital and an additional directors meeting.

The Medical Advisory Committee meets on a bi-monthly basis. We reviewed documentation relating to the MAC and its function. We found a clear constitution and detail of what information is presented at meetings of the MAC had been developed, examples of which included governance reports, complaints, notifiable events/incidents and audits. The MAC reviewed and actively discussed the information to agree actions, identified people responsible for taking the action forward and reviewed progress at subsequent meetings. Minutes of MAC meetings are retained and were available for review during the inspection.

6.4.3 Regulation 26 unannounced quality monitoring visits

Where the entity operating a hospital is a corporate body or partnership or an individual owner who is not in day-to-day management of the practice, Regulation 26 unannounced quality monitoring visits must be undertaken and documented every six months.

We confirmed that Mr Small, Responsible Individual, undertakes a visit to the premises at least every six months in accordance with legislation and reports of the unannounced monitoring visits were available for inspection. We reviewed the most recent reports of 18 June 2019, found it to be of a high standard, and fully compliant with the requirements of Regulation 26.

6.4.4 Complaints management

We confirmed that the hospital has a complaints policy in place. We found this to be in line with the relevant legislation and DoH guidance on complaints handling. A copy of the complaints procedure is made available for patients/and or their representatives. Patients who spoke with us confirmed that they were aware of how to raise any concerns they may have.

Staff who we spoke to demonstrated a good awareness of the processes for management of complaints. A copy of the complaints procedure was available in the hospital.

We noted there had been one written complaint received since our previous inspection. We examined the complaint and noted that it was fully investigated and responded to appropriately. Records kept of the complaint included details of all communications with complainant; the result of any investigation; the outcome and the action taken. The hospital also maintains a record of any verbal complaints and the action taken to address them.

As only one written complaint had been received by the hospital they had not completed a complaint audit. We advised auditing the verbal complaints received to identify any patterns and trends and that any learning should be shared with staff in order to improve care and service delivery.

6.4.5 Notifiable events/incidents

We reviewed the arrangements in respect of the management of notifiable events/incidents and found that all incidents were appropriately reported by the hospital to RQIA.

On review of the incident reporting policy we noted that the policy did not include guidance for staff with regards to Regulation 28 of The Independent Health Care Regulations (Northern Ireland) 2005, which describes events that are reportable to RQIA. The policy also did not reflect how incidents are reported to RQIA through the web portal. Following the inspection we were provided with an updated version of the notifiable events/incident policy on 4 December 2020 which provided clear guidance to staff on reporting to RQIA.

6.4.6 Practising privileges

We reviewed the arrangements relating to practising privileges for medical practitioners working within the hospital. A generic practicing privileges policy and procedure was in place, which outlined the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges. We advised that the policy should be updated to reflect the local arrangements for the management of practising privileges in Fitzwilliam Clinic.

Mr Sinclair outlined the process for granting practising privileges and confirmed medical practitioners meet with the directors prior to privileges being granted. There are systems in place to review practising privileges agreements every two years.

We reviewed three medical practitioner's personnel files and confirmed that there was a written agreement between each medical practitioner and the hospital setting out the terms and conditions of practising privileges, which had been signed by both parties.

We found that hospital management maintained a robust oversight of arrangements relating to practising privileges. We reviewed several personnel files of consultants operating during the course of the inspection, and found that all relevant documentation was present in relation to professional indemnity, insurance and medical appraisals for these doctors.

We advised that going forward the hospital requests the full appraisal document for each medical practitioner rather than the sign off sheet. The appraisal document should be reviewed and scrutinised by the MAC before granting or renewing practising privileges and a record of this review retained. This will provide an added level of assurance for the MAC and can aid in the determination of the agreed scope of practice for each medical practitioner.

All medical practitioners working within the hospital have a designated Responsible Officer (RO). In accordance with the General Medical Council (GMC) all doctors must revalidate every five years. The revalidation process requires doctors to collect examples of their work to understand what they're doing well and how they can improve. A network of experienced senior doctors (called responsible officers) work with the GMC to make sure doctors are reviewing their work. As part of the revalidation process RO's make a revalidation recommendations to the GMC.

Fitzwilliam Clinic is a designated body with the GMC and Mr Small is their RO. We established that some medical practitioners working within the hospital have external ROs due to their prescribed connection with another health care organisation. We discussed with Mr Sinclair how concerns regarding practice are shared with the MAC and the wider HSC. We found that good internal arrangements were in place and the hospital's RO was linked in the regional RO Network.

6.4.7 Risk registers

We found that Fitzwilliam Clinic maintains a corporate risk register. Review of this register evidenced that it included risks in relation to all areas of the hospital that have the potential to impact on the delivery of services. We confirmed that the risk register included actions to mitigate against identified risks and that it is routinely reviewed through the hospital governance structures.

6.4.8 Quality assurance

Ms Shields confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals. These included audits in relation to documentation, discharge planning and infection prevention and control. If required, action plans are developed and learning is embedded into practice to address any shortfalls identified during the audit process.

We evidenced through reviewing minutes and discussion with Mr Sinclair that key quality indicators are measured and discussed at the MAC meeting. We advised that the Acting Manager should produce a key quality indicator report and share this with all staff along with any action plans in place to affect change and influence practice.

6.4.9 Management of operations

We found that there was a clear understanding of the organisational structure within the hospital. Ms Shields is the Acting Manager with overall responsibility for the day-to-day management of Fitzwilliam clinic. Staff who spoke with us were able to describe their roles and responsibilities and were aware of whom to speak to if they had a concern. There was system 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.

We confirmed that the hospital has arrangements in place to monitor the competency and performance of all staff and report to the relevant professional regulatory bodies in accordance to guidance. There are also systems in place to check the registration status of the health care professionals with their appropriate professional bodies on an annual basis.

We reviewed and confirmed that the statement of purpose and patient's guide are kept under review, revised and updated when necessary and these are available on request.

We observed that the RQIA certificate of registration was up to date and displayed appropriately. Review of insurance documentation confirmed that current insurance policies were in place.

The hospital has a Whistleblowing policy and procedure in place to enable staff to report concerns they may have regarding poor practice. Staff who spoke with us confirmed that they were aware of the policy and who to contact if they had any concerns.

Areas of good practice: Is the service well led?

We found examples of good practice in relation to organisational governance; the management of complaints and incidents, arrangements in relation to practising privileges and quality assurance.

Areas for improvement: Is the service well led?

No areas for improvement were identified during the inspection in relation to the hospital being well led.

	Regulations	Standards
Areas for improvement	0	0

6.5 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

6.5.1 Staffing

We reviewed the staffing arrangements within the hospital. Discussion with Ms Shields, staff members and a review of the duty rotas demonstrated that there was sufficient staff in various roles to fulfil the needs of the hospital and patients.

It was confirmed that all new staff undertake an induction. We reviewed the range of induction templates available for specific roles within the hospital. Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place. We reviewed appraisal records and confirmed that they had been completed on an annual basis.

We found that there were systems in place for recording and monitoring all aspects of staff ongoing professional development, including specialist qualifications and training. Staff reported they felt supported and involved in discussions about their personal development. Discussion with the Acting Manager and review of a sample of training records confirmed that the hospital provides annual mandatory training appropriate to staff roles and responsibilities 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. The hospital affords staff opportunities to undertake specialist qualifications such as wound care management.

Discussion with Ms Shields confirmed that a robust system was in place to review the professional indemnity status of all staff that require individual indemnity cover. Review of personnel files confirmed that medical practitioners had appropriate professional indemnity insurance in place.

We found that there was a process in place to review the registration details of all health and social care (HSC) professionals. Personnel files of HSC Medical Practitioners and identified Private Doctors' were reviewed and evidenced the following was in place:

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

As previously reported in section 6.4.6 we confirmed that each Medical Practitioner had an appointed Responsible Officer (RO).

6.5.2 Recruitment and selection

We reviewed how recruitment and selection of staff is undertaken by the hospital. We found there was a recruitment and selection policy and procedure available which was comprehensive and reflected best practice guidance.

We found that a number of staff of various grades and professions have been recruited since the previous inspection. We reviewed a sample of four personnel files of newly recruited staff. This provided us with assurance that systems and processes were in place that ensured that all recruitment documentation as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 had been sought and retained for inspection.

6.5.3 Surgical services

We reviewed the provision of surgical services within the hospital. We found 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 theatre manager, the Consultant medical practitioner and the administration office. 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 and associated risks. The theatre manager reported that the Registered Persons are quick to respond to any requests for additional or new equipment.

Staff who spoke with us confirmed that the Consultant performing the surgical procedure meets with the patient, prior to commencing the procedure, to discuss the surgery and gain consent.

Additionally for those patients requiring an anaesthetic, the Anaesthetist who administers the anaesthetic visits the patient prior to surgery to, assess the patient's general medical fitness, review their medication, explain the type of anaesthetic to be used and discuss options for post-operative pain relief.

We confirmed that there is an identified member of nursing staff, with theatre experience, in charge of the operating theatre. Through discussion with staff and observation of practice we confirmed that patients are monitored during and immediately following surgery. A discharge criteria was in place to check the patient's condition and appropriateness to transfer to the waiting area or home following the procedure. The anaesthetist was present throughout the operation and was available onsite until the patient had recovered from the immediate effects of the anaesthetic.

We reviewed the surgical register of operations, which is maintained for all surgical procedures undertaken in the hospital and found that it contained all of the information required by legislation. Staff informed us that the World Health Organisation (WHO) model for surgical checklists is used in the hospital. Completion of the surgical checklists is audited as part of the hospitals clinical governance systems.

We met with one Consultant surgeon who spoke very positively regarding their experiences in the hospital and reported that it was well managed. The Consultant advised that they would be happy to raise any concerns and knew who to contact if they had any issues that required to be addressed.

We reviewed the venous thromboembolism (VTE) policy and were advised by the theatre manager that this was currently being reviewed and updated. We informed the theatre manager that all surgical patients must have a VTE risk assessment in keeping with the National Institute for Health Care Excellence (NICE). We advised that evidence to show that staff are adhering to the revised policy must be in place, with responsibility for oversight of adherence to the policy resting with the MAC and the hospital's governance structures. We recommended that the following matters with, respect to the management of venous thromboembolism (VTE), are taken into consideration when updating the policy:

- review the current VTE management policy and ensure that it is in keeping with NICE guideline [NG89];
- ensure that the MAC contributes to and approves the updated hospital VTE policy;
- ensure that VTE risk assessments are undertaken and documented in respect of all patients admitted for surgical procedures; and
- develop a rolling audit programme to provide assurance that the VTE policy is being adhered to.

6.5.4 Safeguarding

We reviewed the arrangements in place for safeguarding and found that policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. The policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The relevant contact details for onward referral to the local Health and Social Care Trust (HSCT) were included; should a safeguarding issue arise. It was confirmed that copies of the regional policy entitled 'Co-operating to Safeguard Children and Young People in Northern Ireland' (August 2017) and the regional guidance document entitled 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015) were both available for staff reference.

We discussed safeguarding with staff and found good awareness of the types and indicators of abuse, along with the actions to be taken in the event of a safeguarding issue being identified. Some of the staff were not aware who the nominated safeguarding lead in the hospital was. This was discussed and it was agreed that the name of the safeguarding lead for children and adults would be clearly identified in the policies. Review of the staff training records demonstrated that not all relevant staff had received training in safeguarding children and adults as outlined in the Minimum Care Standards for Independent Healthcare Establishments July 2014. An area for improvement against the standards has been made in this regard.

6.5.5 Resuscitation and management of medical emergencies

We reviewed arrangements for management of medical emergencies and resuscitation of patients and visitors to the hospital. The hospital has a policy and procedure for dealing with medical emergencies and cardio pulmonary resuscitation (CPR) that was in accordance with the Resuscitation Council UK guidelines. Discussion with staff demonstrated that they have a good understanding of the actions to be taken in the event of a medical emergency and the location of medical emergency medicines and equipment.

We reviewed the emergency trolley and evidenced that emergency medicines and equipment was available. We noted that a system was in place to ensure that emergency medicines and equipment do not exceed their expiry date.

A review of training records and discussion with staff confirmed that staff have undertaken basic life support training and updates. We were informed that there is at least one staff member with

advanced life support training on duty at all times. Some reception staff reported that they had not received training in basic life support. An area for improvement against the standards has been made in this regard.

6.5.6 Infection prevention and control (IPC)

We reviewed the arrangements for infection prevention and control (IPC) and the decontamination procedures in place throughout the hospital, to ensure that the risk of infection for patients, visitors and staff are minimised. We found there were clear lines of accountability for infection prevention and control (IPC) and the hospital has a designated IPC Lead Nurse and access to an external microbiologist.

We reviewed a range of IPC policies and procedures, which were located within an IPC folder. We found that arrangements were in place to ensure the decontamination of reusable medical devices in line with manufacturer's instructions. Staff who spoke with us confirmed single use equipment is used where possible.

We found that staff had been provided with IPC training commensurate with their role. Staff who we spoke with confirmed to us that they had a good knowledge and understanding of IPC measures.

We reviewed a range of IPC audits that included environmental cleanliness and hand hygiene and noted that the compliance rates were high and action plans were in place to address any areas of non-compliance.

We found that the hospital was clean, tidy and well maintained. Detailed cleaning schedules were in place and appropriately completed. Patient and non-patient areas of the hospital were free from excess clutter and organised to allow for ease of cleaning.

We found that patient equipment was clean although staff should ensure that all equipment is free of adhesive tape or labels. Additionally the theatre table gel pressure-relieving pad was damaged and could not be effectively decontaminated. An area for improvement against the standards was made in this regard.

Personal protective equipment (gloves, aprons, facemasks) was available for staff and alcohol hand santiser was available for hand hygiene purposes. Clinical hand wash sinks were clean and observed to be only used for hand hygiene purposes. Sharps and waste were managed in line with best practice.

6.5.7 Environment

We found that the overall environment including the entrance, reception area, treatment rooms and consultation rooms were of a high standard of maintenance and décor. We were informed of plans to modernise the theatre and preparation area and install new smart storage systems for equipment.

We reviewed building services documents and spoke with estates and facilities manager who demonstrated that suitable arrangements are in place for maintaining the environment in accordance with current legislation and best practice guidance.

The following documents were reviewed:

- fire risk assessment;
- BS5839 fire detection & alarm maintenance/test certificates;
- BS5266 emergency lighting maintenance/test certificates;
- BS5306 firefighting equipment annual maintenance/test certificate;
- BS7671 periodic inspection report for the electrical installation;
- portable electrical appliances (PAT) inspection/test certificate;
- water safety/legionella risk assessment;
- thermostatic mixing valve (TMV) maintenance/test certificates;
- lifting operations & lifting equipment (LOLER) thorough examination certificates for passenger lift; and
- gas safe register inspection/test reports for space heating boilers.

We found that the most recent water safety/legionella risk assessment (LRA) was completed in October 2018. Thermal & chemical sterilisation of the hot/cold water storage & distribution system has been completed in 2019. Monthly temperature monitoring records indicated compliance with HSG 274 recommendations. Water sampling assurance test analysis was planned for January 2020. The water safety group (WSG) had recommended the implementation of LRA training for both the Practice manager and the Nurse Manager at the WSG annual meeting. This training was scheduled and completed on the 22 May 2020.

A fire risk assessment completed on 19 September 2019 was evaluated as satisfactory and associated fire safety control procedures were implemented. A number of minor defects were listed as requiring remedial action: repairs were required to several fire doors and fire drills were not completed at appropriate intervals. It was noted that BS5839 weekly fire detection and alarm building user tests were not always completed as recommended by BS5839. During the periods 27 June 2019 to 23 August 2019, and 5 November 2019 to 28 November 2019 fire alarm weekly tests were not completed.

Ms Shields advised that this lapse in testing had occurred due to the facility being utilised to maximum capacity, but that in future arrangements would be implemented to ensure BS5839 testing occurred each week. An area for improvement against the regulations was made in this regard.

We found that the Medical Gas Pipeline System (MGPS) HTM 02-01 audit reports were completed in accordance with recommended guidelines. A ‘permit to work’ system is operated in compliance with HTM 02-01. We found that the mechanical ventilation systems had been installed and were maintained in accordance with the current best practice guidance. Ventilation system HTM 03-01 audits and maintenance works were implemented in accordance with good practice. Quarterly inspections were completed in March, May & September 2019.

Passenger lift installation LOLER thorough examination inspections were completed in January 2019 & July 2019, no defects/concerns were listed as requiring remedial action.

6.5.8 Medicines Management

We reviewed the arrangements in place for the management of medicines within the hospital to ensure that medicines are safely, secure and effectively managed in compliance with legislative requirements, professional standards and guidelines.

We found there were written policies and procedures detailing the arrangements for the management of medicines. These were kept under review and included the management of controlled drugs, the management of injectable medicines and purchasing for safety.

The medicines management policy and procedures require medicine expiry date checks to be performed at monthly intervals. However, we found that the last medicine expiry date check was done on 3 October 2019. There were two medicines in stock with October 2019 expiry dates. An area for improvement against the standards has been made in this regard.

Nursing staff had recently attended a medicines management training update on 2 October 2019. Medicines were observed to be prescribed and administered in accordance with legislative requirements and professional standards.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Medicines were observed to be stored securely and in compliance with the manufacturer's requirements. There were clear lines of responsibility with regard to the control of medicine keys.

We found that the management of controlled drugs was in accordance with the provisions of legislation, complied with professional standards, and published guidance. There were Standard Operating Procedures that covered all aspects of the management of controlled drugs in line with Department of Health guidelines for the management of controlled drugs in primary care. The Accountable Officer for Fitzwilliam Clinic is accountable for all aspects of the management of controlled drugs and performs quarterly audits. The receipt, storage, administration and disposal of all controlled drugs subject to record keeping requirements were maintained in a controlled drug record book; we found that this had been completed in a satisfactory manner.

We evidenced that medicine records had been completed in a satisfactory manner. Patients were provided with detailed information regarding any medicines prescribed. Medicines that were no longer required or expired medicines were disposed of appropriately.

There were systems in place for the management of drug alerts, medical device alerts and safety warnings about medicines.

Areas of good practice: Is care safe?

We found examples of good practice in relation to staff recruitment; induction; training; supervision and appraisal; the provision of surgical services; aspects of the environment; and aspects of medicines management.

Areas for improvement: Is care safe?

We identified areas for improvement in relation to safeguarding; the provision of basic life support training for reception staff; the decontamination of reusable equipment and ensuring pressure-relieving gel pads are fit for purpose; fire detection systems and medicine expiry checks.

	Regulations	Standards
Areas for improvement	1	4

6.6 Is care effective?

The right care, at the right time in the right place with the best outcome.

6.6.1 Care pathway

We reviewed the patient care pathway through the hospital. We found that patients are provided with comprehensive information prior to their surgical procedure, which outlines any pre-operative and post-operative requirements.

We reviewed three patient records and found that the care records contained comprehensive information relating to pre and post-operative care, which clearly outlined the patient pathway and included the following:

- patient personal information;
- pre-operative care plans;
- pre-operative checks;
- signed consent forms;
- surgical safety checklist;
- procedure notes;
- medical notes;
- post-operative checks; and
- discharge plan.

Patients who spoke with us confirmed that they had received written information regarding their treatment and had the opportunity to meet with their surgeon prior to going to theatre to discuss the nature of the surgery, the risks, complications and expected outcomes before signing the consent form. The Consultant Surgeon and the patient had signed the consent forms we reviewed.

6.6.2 Records Management

We reviewed the management of records within the hospital. We confirmed the hospital is registered with the Information Commissioner's Office (ICO). Through discussion with staff, we found that the hospital is complying with the General Data Protection Regulations (GDPR).

Staff who spoke with us confirmed they had a good knowledge of effective records management. 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. We advised that the legislation within the records management policy should be updated to reflect GDPR.

The management of records within the hospital was found to be in line with legislation and best practice. Patient records were held in secure cabinets and computerised records were accessed by only those with password permission. Records required by legislation were retained and made available to inspectors.

We found systems were in place to audit the patient care records as outlined in the establishment's quality assurance programme.

6.6.3 Discharge planning

We found robust systems were in place to ensure that agreed discharge arrangements are recorded and co-ordinated with all other professionals that are involved in the patient's ongoing care and treatment.

We reviewed the discharge arrangements and established that discharge criterion is in place and we were advised the Consultant who performs the procedure confirms the patient's suitability for discharge from the hospital.

A clinical discharge summary is completed prior to the patient leaving the hospital. A discharge letter is provided to the patient's General Practitioner (GP) to outline the care and treatment provided within the hospital.

Patients are provided with a 24 hour telephone number to contact the hospital if they have any concerns following discharge. The hospital has arrangements in place to contact and make referral to the Consultant who was responsible for the patient's care.

Areas of good practice: Is care effective?

We found examples of good practice in relation to record keeping; record management; and discharge planning.

Areas for improvement: Is care effective?

No areas for improvement were identified during the inspection in relation to effective care.

	Regulations	Standards
Areas for improvement	0	0

6.7 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

6.7.1 Person centred care

We spoke with patients, reviewed care records, observed practice and met with various grades of staff to understand how the hospital ensures that patients receive person centred care; we found good systems in place across the hospital.

Patients told us they were very happy with their care and we observed positive interactions between staff and patients throughout our inspection. We observed staff treating patients with compassion, dignity and respect, introducing themselves and explaining procedures to patients in a kind and caring manner.

During the consultation and treatment processes we observed that patient's privacy, modesty and dignity was respected at all times

6.7.2 Breaking bad news

We confirmed that the hospital has a Breaking Bad News Policy for delivering bad news to patients and/or their representatives, which is accordance with the Breaking Bad News Regional Guidelines 2003.

We spoke with staff who confirmed professionals who have experience in communication skills and act in accordance with the hospital's policy deliver that bad news to patients and/or their representatives.

Where bad news is shared with others, staff confirmed that consent must be obtained from the patient and is documented in the patient's records. Following a patient receiving bad news, future treatment options are discussed fully with the patient and documented within their individual care records. Staff provide support to the patient and/or their representative to help them process the information shared. We were advised that, with the consent of the patient, information is shared with the patient's GP and/or other healthcare professionals involved in their ongoing treatment and care.

6.7.3 Patient engagement

We examined the methods used by the hospital to obtain the views of patients and/or their representatives through speaking with patients, staff and reviewing relevant documentation. We found this to be an integral part of the service delivered in the hospital. Patients are offered an opportunity to provide feedback on their care through completion of a questionnaire.

We found that information received from these questionnaires was available to patients and other interested parties within an annual report, which is made available through the hospital's website. We reviewed the most recent annual report and 43 completed questionnaires and noted that patients were highly satisfied with the care and treatment provided.

Areas of good practice: Is care compassionate?

We found examples of good practice in relation to ensuring the core values of privacy, dignity and respect were upheld; arrangements for delivering bad news in a compassionate and supportive manner; and considering feedback from patients to improve the quality of services provided.

Areas for improvement: Is care compassionate?

No areas for improvement were identified during the inspection in relation to compassionate care.

	Regulations	Standards
Areas for improvement	0	0

6.8 Equality data

The arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients was discussed with Ms Shields.

6.9 Patient and staff views

During our inspection, the hospital staff distributed patient questionnaires on our behalf for completion and return to RQIA. We received three completed patient questionnaires and found that patients who responded were very satisfied that the hospital was providing safe, effective, compassionate and well led care.

We invited staff to complete an electronic questionnaire during the inspection. We did not receive any completed staff patient questionnaires following the inspection, however, staff who spoke with us reported that they felt supported and valued by the senior management team in the hospital.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Denise Shields (Acting Manager) and the theatre manager as part of the inspection process. The timescales commence from the date of inspection.

The Registered Provider/Manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to enforcement action. It is the responsibility of the Registered Provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed because 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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 and the Department of Health (DOH) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The Registered Provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan	
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 25 (4) (a) & (d) **Stated:** First time **To be completed by:** 31 January 2020	The Responsible Person shall ensure that: • weekly fire detection and alarm system test activations are completed in compliance with BS5839 recommendations; and • the fire risk assessment works action plan recommendations should be implemented Ref: 6.5.7
	Response by Registered Person detailing the actions taken: Additional staff have been trained with protected time alloted each week to ensure weekly fire detection and alarm system test activations are completed in compliance with BS5839. The fire risk assessment action plan recommendations were implemented and completed as required.

Action required to ensure compliance with The Minimum Care Standards for Independent Healthcare Establishments (2014)	
Safeguarding	
Area for improvement 2 **Ref**: Standard 3.1, 3.8 **Stated:** First time **To be completed by:** 2 January 2020	The Responsible Person shall ensure: • the name of the safeguarding lead within the hospital for children and adults is clearly identified within the safeguarding policies and procedures and all staff informed • All relevant staff should receive safeguarding training in safeguarding for the protection of children and adults. Ref: 6.5.4
	Response by Registered Person detailing the actions taken: Safeguarding Lead: The Staff Nurse that is trained in safeguarding for adults and children has been clearly identified and notified to all staff within the clinic. All staff now updated and also receive annual training in relation to safeguarding for the protection of children and adults.
Dealing with Medical Emergencies	
Area for improvement 3 **Ref**: Standard 18.2 **Stated:** First time **To be completed by:** 2 January 2020	The Responsible Person shall ensure that all reception staff are trained in basic life support skills. Ref: 6.5.5
	Response by Registered Person detailing the actions taken: Reception staff skills have been updated with basic life support as part of their mandatory annual training plan.
Infection Prevention and Control	
Area for improvement 4 **Ref**: Standard 20.5 **Stated:** First time **To be completed by:** 2 January 2020	The Responsible Person shall ensure: • reusable equipment is free of adhesive labels allowing for appropriate decontamination in line with manufacturer's instructions and best practice guidance; • the pressure-relieving pad is repaired or replaced to allow effective cleaning. Ref: 6.5.6
	Response by Registered Person detailing the actions taken: The Theatre Manager has reviewed, cleaned and audited all equipment to ensure that it is free from adhesive labels to ensure all infection prevention and control protocols and decontamination are met. The pressure-relieving pad has been replaced. Additional audit and check put in place by the Theatre Manager.

Medicines Management	
Area for improvement 5 **Ref**: Standard 26 **Stated:** First time **To be completed by:** 2 January 2020	The Responsible Person shall ensure that medicine expiry date checks are performed on a monthly basis. Ref: 6.5.8
	Response by Registered Person detailing the actions taken: The audit process has been amended to detail that monthly checks for expiry dates are carried out. Regular spot checks are carried out to ensure completion.

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

The Regulation and Quality Improvement Authority

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

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews