Announced Care Inspection Report
19 February 2019

Fitzwilliam Clinic

Type of Service: Independent Hospital – Surgical Services
Address: 70-72 Lisburn Road, Belfast, BT9 6AF
Tel No: 028 9032 3888
Inspectors: Stephen O'Connor and Jo Browne

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 service

Fitzwilliam Clinic is registered as an independent hospital with a private doctor category of care. The hospital provides a range of services and treatments, including outpatient clinics on all aspects of cosmetic, plastic and reconstructive surgery and some general surgical procedures are undertaken. There are no overnight beds provided in this hospital.

3.0 Service details

Organisation/Registered Provider: Fitzwilliam Partnership **Registered persons:**	**Registered Manager:** Ms Sheila Jordan

Mr James Small Mr Stephen Sinclair Mr Andrew Kennedy	
Person in charge 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	

4.0 Inspection summary

An announced inspection took place on 19 February 2019 from 10:00 to 15:30.

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).

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the hospital was delivering safe, effective and compassionate care and if the service was well led.

Examples of good practice were evidenced in all four domains. These related to: patient safety in respect of staff training and development; recruitment; the provision of surgical services; resuscitation arrangements and the management of medical emergencies; and the environment. Other examples included: the management of the patients' care pathway; communication; records management, practising privileges arrangements and engagement to enhance the patients' experience.

One area for improvement against the regulations and two areas for improvement against the standards have been made. The area for improvement against the regulations relates to the registered persons or their nominated representative undertaking unannounced quality monitoring visits. An area for improvement against the standards made during the previous care inspection in relation to generating an action plan for each monthly clinical record audit had not been met and is stated for the second time. An additional area for improvement against the standards has been made to develop a safeguarding children's policy.

The findings of this report will provide the hospital with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	2

Details of the quality improvement plan (QIP) were discussed with Ms Sheila Jordan, registered manager and the practice 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.

4.2 Action/enforcement taken following the most recent care inspection dated 20 June 2017

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 20 June 2017.

5.0 How we inspect

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

- notifiable events since the previous care inspection
- the registration status of the hospital
- written and verbal communication received since the previous care inspection
- the previous care inspection report
- the returned QIP from the previous care inspection

A poster informing patients that an inspection was being conducted was displayed.

During the inspection the inspectors met with Ms Sheila Jordan, registered manager, the practice manager, and a registered nurse. A tour of some areas of the premises was also undertaken.

A sample of records were examined during the inspection in relation to the following areas:

- staffing
- recruitment and selection
- surgical services
- safeguarding
- resuscitation and management of medical emergencies
- infection prevention and control and decontamination
- clinical record recording arrangements
- management of patients
- patient information and decision making
- practising privileges arrangements
- management and governance arrangements
- maintenance arrangements

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

The findings of the inspection were provided to Ms Jordan and the practice manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 20 June 2017

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

6.2 Review of areas for improvement from the last care inspection dated 20 June 2019

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 19 (2) **Stated:** First time	The registered person shall ensure that enhanced AccessNI disclosure checks are undertaken and received prior to the commencement of employment for all new staff recruited, including self-employed staff. The identified staff member must be supervised at all times until the enhanced AccessNI check has been received.	**Met**
	Action taken as confirmed during the inspection: Review of records and discussion with Ms Jordan evidenced that one new staff member has commenced work in the hospital since the previous inspection. Review of the identified staff members personnel file evidenced that an AccessNI enhanced disclosure check had been sought and reviewed prior to the staff member commencing work. All relevant information in relation to the check had been recorded. Discussion with Ms Jordan evidenced that she had a clear understanding of the requirement to undertake AccessNI enhanced disclosure checks prior to new staff commencing work in the hospital.	
Area for improvement 2 **Ref:** Regulation 19 (2) Schedule 2 **Stated:** First time	The registered person shall ensure that all of the information as outlined in Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005 is sought and retained, prior to the commencement of employment.	**Met**

	Action taken as confirmed during the inspection: As discussed, the personnel file for one staff member recruited since the previous inspection was reviewed. Review of this personnel file evidenced that all information as outlined in schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005 had been sought and retained.	
Area for improvement 3 **Ref:** Regulation 18 (1) **Stated:** Second time	The registered person shall ensure there is at least one person on duty at all times with certified advanced life support (ALS) training. Records should be retained.	**Met**
	Action taken as confirmed during the inspection: Review of records evidenced that five members of staff had completed advanced life support training during August 2017. The training certificates stated that the training was valid for four years. In addition a number of medical practitioners have completed ALS training. Ms Jordan and staff confirmed that at least one staff member with ALS training is on duty at all times.	
Action required to ensure compliance with The Minimum Care Standards for Independent Healthcare Establishments (2014)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 10.11 **Stated:** First time	The registered person shall further develop induction record templates to provide more detail and be role specific. Induction records should be signed and dated by the staff member and the mentor.	**Met**
	Action taken as confirmed during the inspection: Review of records evidenced that role specific induction programmes have been developed. The induction templates include space for the inductor and inductee to sign and date when individual topics are discussed.	
Area for improvement 2 **Ref**: Standard 10.1 **Stated:** First time	The registered person shall make arrangements to monitor the registration status of all nursing staff, at the time of renewal, on an annual basis.	**Met**
	Action taken as confirmed during the inspection:	

	Ms Jordan confirmed that she is responsible for verifying that all nursing staff are on the Nursing and Midwifery Council (NMC) professional register. Ms Jordan maintains a professional body registration spreadsheet and undertakes checks of live registers when required.	
Area for improvement 3 **Ref**: Standard 9.4 **Stated:** First 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 who were spoken with.	**Not met**
	Action taken as confirmed during the inspection: Review of records evidenced that a number of audits to include a monthly clinical record audit are routinely undertaken. However, no evidence was available to demonstrate that an action plan had been generated as a result of these audits. Additional information in this regard can be found in section 6.7 of this report. This area for improvement has not been addressed and has been stated for the second time.	
Area for improvement 4 **Ref**: Standard 12.7 **Stated:** First time	The registered person shall ensure that minutes of staff meetings are made available to staff who are unable to attend the meeting.	**Met**
	Action taken as confirmed during the inspection: Minutes of staff meetings held on the 28 and 29 November 2018 were reviewed during the inspection.	

6.3 Inspection findings

6.4 Is care safe?

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

Staffing

A review of duty rotas, discussion with staff demonstrated that there was sufficient staff in various roles to fulfil the needs of the hospital and patients. There is a multi-professional team which includes consultant surgeons, anaesthetists and nurses.

Discussion with Ms Jordan and the practice manager confirmed that the theatre and outpatient clinic lists are reviewed and staff rostered accordingly to meet the needs of patients. A number of bank/relief nurses who have experience working in the hospital are available to ensure that adequate staffing levels are provided.

As discussed, induction programme templates were in place relevant to specific roles within the hospital. A sample of one evidenced that induction programmes had been completed when new staff join the hospital.

Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place. Staff confirmed they felt supported and involved in discussions about their personal development. Review of a sample of one evidenced that appraisals had been completed on an annual basis.

There were systems in place for recording and monitoring all aspects of staff ongoing professional development, including specialist qualifications and training. Ms Jordan confirmed that there is a system in place to ensure that all staff receive appropriate training to fulfil the duties of their role in keeping with the RQIA training guidance. The hospital facilitates at least one core continuing professional development (CPD) training day a year. In addition suppliers facilitate lunch and learn sessions routinely throughout the year.

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.

Review of records and discussion with Ms Jordan evidenced that a robust system was in place to review the professional indemnity status of all staff who require individual indemnity cover. Review of personnel files confirmed that medical practitioners had appropriate professional indemnity insurance in place and received the required annual appraisals.

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

Discussion with Ms Jordan and review of documentation evidenced that one private doctor provides services in the hospital. Review of the identified private doctors' details confirmed there was evidence of the following:

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

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

Recruitment and selection

Ms Jordan confirmed that one staff member has been recruited since the previous inspection. A review of the personnel file for the identified staff demonstrated that all the relevant information as outlined in schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained.

There was a recruitment policy and procedure available. The policy was comprehensive and reflected best practice guidance.

A staff register in keeping with schedule 3 Part II (6) of The Independent Health Care Regulations (Northern Ireland) 2005 is maintained. Ms Jordan confirmed the staff register is kept up-to-date.

Surgical services

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 Ms Jordan and the surgeon supported by nursing 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.

Review of the patient care records and discussion with staff confirmed that the anaesthetist who administers the anaesthetic visits the patient prior to surgery to:

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

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

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

Where applicable, the anaesthetist is present throughout the operation and is available onsite until the patient has recovered from the immediate effects of the anaesthetic.

On discussion staff confirmed that the surgical checklist based on the World Health Organisation (WHO) model is used in the hospital. Completion of the surgical checklists is audited as part of the hospital's clinical governance systems.

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

The hospital has discharge criteria in place from theatre recovery to home.

Fitzwilliam Clinic has a contract with Belfast Link Labs to analyse all biopsy and pathology samples taken during surgical procedures.

Safeguarding

It was confirmed that the hospital only provides services to patients aged 16 and over.

Staff spoken with were aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified. Staff were aware of who the nominated safeguarding lead was within the hospital.

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

A policy and procedures were in place for the safeguarding and protection of adults at risk of harm. The policy included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult. As some patients who attend the hospital reside in the Republic of Ireland the relevant contact details for onward referral to the local Health and Social Care Trust and the Republic of Ireland should a safeguarding issue arise were included.

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.

It was confirmed that the hospital does not have a safeguarding children's policy. An area for improvement against the standards has been made in this regard.

Resuscitation and management of medical emergencies

The hospital has a policy and procedure for dealing with medical emergencies.

Discussion with staff confirmed they were aware what action to take in the event of a medical emergency.

All medical practitioners have received training in basic life support.

An emergency trolley in the recovery room area adjacent to the theatre was reviewed and was found to contain various medicines and medical emergency equipment. It was confirmed that following a review of best practice literature; advice from an advanced life support trainer and discussion with an anaesthetist a decision was taken in regards to what emergency medicines and equipment would be retained.

A robust system was in place to ensure that emergency medicines and equipment do not exceed their expiry date. There was an identified individual with responsibility for checking emergency medicines and equipment.

Discussion with Ms Jordan in relation to the arrangements regarding patients with a "Do Not Resuscitate" (DNR) order in place confirmed that patients who would have a DNR order in place would not meet the normal admission criteria for elective surgery within the hospital.

During the inspection a patient who was attending an outpatient appointment to get a dressing changed informed staff that she had been feeling unwell for several days. The nurse asked the anaesthetist in theatre to review the patient. The anaesthetist assessed the patient and requested an electrocardiogram (ECG) which was immediately undertaken. The ECG showed recent changes and in response to the ECG results and anaesthetist's review the hospital managed this as a medical emergency and requested a cardiac ambulance. The patient left the hospital in a cardiac ambulance. Inspectors reflected to staff that this situation was managed appropriately.

Infection prevention and control and decontamination procedures

There were clear lines of accountability for infection prevention and control (IPC). The hospital has a designated IPC lead nurse.

Ms Jordan confirmed that an external infection prevention and control advisor undertakes an annual review of IPC arrangements in the hospital and that the same advisor is available for advice and support when required. A microbiologist is also available for advice when required.

There was a range of information for patients and staff regarding hand washing techniques.

Arrangements were in place to ensure the decontamination of equipment and reusable medical devices in line with manufacturer's instructions and current best practice. The hospital has a contract in place with the CSSD (Central Sterile Services Department) at the Ulster Hospital to decontaminate reusable medical instruments.

Staff confirmed single use equipment is used where possible.

Staff have been provided with IPC training commensurate with their role.

Discussion with staff confirmed they had a good knowledge and understanding of IPC measures.

The hospital was found to be clean, tidy and well maintained.

A review of infection prevention and control arrangements indicated that very good infection control practices are embedded in the hospital.

There were a range of IPC policies and procedures in place which were located within an IPC manual.

Environment

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

Detailed cleaning schedules were in place for all areas which were signed on completion. A colour coded cleaning system was in place.

Ms Jordan confirmed that arrangements are in place to ensure the fire and legionella risk assessments are reviewed annually.

Arrangements are in place to ensure the intruder alarm, fire detection system; firefighting equipment, passenger lift and gas heating boiler are serviced in keeping with manufacturer's instructions.

It was also confirmed that portable appliance testing (PAT) of electrical appliances is undertaken and that the fixed electrical wiring installation has been inspected.

Areas of good practice

There were examples of good practice found in relation to staff recruitment, induction, training, supervision and appraisal, management of medical emergencies, infection prevention control and decontamination procedures and the environment.

Areas for improvement

A safeguarding children's policy should be developed and implemented.

	Regulations	Standards
Areas for improvement	0	1

6.5 Is care effective?

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

Care pathway

Patients are provided with a comprehensive information pack prior to their admission which outlines any pre-operative requirements and the arrangements for their stay in the hospital. Copies of the patient guide are made available to all patients on arrival.

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

- patient personal information
- holistic assessments
- pre-operative checks
- signed consent forms

- surgical safety checklist
- VTE risk assessment
- operation notes
- anaesthetic notes
- medical notes
- nursing notes
- intra-operative care plans
- recovery care plans
- post-operative care plans
- a statement of the patient's condition prior to discharge
- discharge plan

Ms Jordan confirmed that the consultant surgeon discusses the nature of the surgery, the risks, complications and expected outcomes before signing the consent form. The consent forms reviewed by the inspectors were signed by the consultant surgeon and the patient.

Records

Review of documentation confirmed that the hospital has a range of policies and procedures in place for the management of records which includes the arrangements for the creation, use, retention, storage, transfer, disposal of and access to records. The hospital also has a policy and procedure in place for clinical record keeping in relation to patient treatment and care which complies with GMC guidance and Good Medical Practice.

Staff spoken with were aware of the importance of effective records management and records were found to be held in line with best practice guidance and legislative requirements. Patient care records are held in secure locked filing cabinets. Computerised records are accessed using individual usernames and passwords.

The hospital is registered with the Information Commissioner's Office (ICO). Discussion with Ms Jordan and review of the management of records policy confirmed that patients have the right to apply for access to their clinical records in accordance with the General Data Protection Regulations that came into effect during May 2018 and where appropriate ICO regulations and Freedom of Information legislation.

Records required by legislation were retained and made available for inspection at all times.

The practice manager confirmed that a patient register in keeping with schedule 3 Part II 1 of The Independent Health Care Regulations (Northern Ireland) 2005 is maintained and kept up-to-date.

Discharge planning

The hospital has a discharge policy and procedure in place.

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

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

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

Areas of good practice

There were examples of good practice found in relation to the patient care pathway and discharge planning.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Areas for improvement	0	0

6.6 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.

Dignity, respect and rights

Discussion with Ms Jordan and staff regarding the consultation and treatment process confirmed that patients' modesty and dignity is respected at all times. Three consultation rooms are available in the hospital, these facilitate patients to meet privately with medical practitioners.

Private individual changing rooms are available close to the theatre. The hospital has a recovery area that can accommodate up to two patients which are in close proximity with each other and divided by curtains. The design and size presents challenges to nursing and medical staff in ensuring the privacy and confidential of patients. Ms Jordan confirmed that, where possible, only one patient will be cared for in the recovery area at a time.

Patients can exit the hospital without having to go through the reception/waiting area.

It was confirmed through the above discussion and observation that patients are treated in accordance with the DOH standards for Improving the Patient & Client Experience.

Ms Jordan and staff confirmed that patients meet with the medical practitioner undertaking the treatment and are fully involved in decisions regarding their care. Patients' wishes are respected and acknowledged by the hospital.

Discussion with Ms Jordan and staff confirmed that patients are treated and cared for in accordance with legislative requirements for equality and rights.

Discussion with staff and observation of telephone interactions with patients evidenced that patients are treated with compassion, dignity and respect. No patients were available during the inspection to speak with the inspectors.

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

Review of patient care records and discussion with staff confirmed that treatment and care is planned and developed with meaningful patient involvement; facilitated and provided in a flexible manner to meet the assessed needs of each individual patient.

A policy and procedure was in place in relation to confidentiality which included the arrangements for respecting patient's privacy, dignity and providing compassionate care and treatment.

Breaking bad news

The hospital has a policy and procedure for delivering bad news to patients and/or their representatives which is accordance with the Breaking Bad News Regional Guidelines 2003.

The hospital retains a copy of these guidelines and this is accessible to staff.
Ms Jordan confirmed that bad news is delivered to patients and/or their representatives by senior clinicians who have experience in communication skills.

Where bad news is shared with others, Ms Jordan confirmed that consent must be obtained from the patient and documented in the patient's records.

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

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

Patient consultation

The hospital obtains the views of patients and/or their representatives on a formal and informal basis as an integral part of the service they deliver. All questionnaire responses are reviewed and quarterly audits are undertaken.

Assurances were given that all completed satisfaction surveys are reviewed and any issues/suggestions identified by patients are actioned.

The results of audits are included in the quarterly clinical and administration audit report for discussion at the Medical Advisory Committee (MAC) meeting.

Comments provided by patients in the most recent satisfaction surveys are as follows:

- "Having experience of a smaller clinic, I found Fitzwilliam preferable in terms of results reporting…"
- "Very happy with everything."
- "Excellent service."
- "A friendly and efficient service."
- "Very reassuring, staff made everything very calm and lovely."
- "Everyone was very pleasant and I am delighted with the result. Thank you."

Areas of good practice

There were examples of good practice found in relation to maintaining patient confidentiality ensuring the core values of privacy and dignity were upheld, providing the relevant information to allow patients to make informed choices and patient consultation.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Areas for improvement	0	0

6.7 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.

Management and governance arrangements

There was a clear organisational structure within the hospital and staff were able to describe their roles and responsibilities and were aware of who to speak to if they had a concern. Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. There was a nominated individual with overall responsibility for the day to day management of the hospital.

In keeping with regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005, where the registered provider is a partnership an unannounced quality monitoring visit should be undertaken at least six monthly. There were no records to confirm these visits had been undertaken. An area for improvement against the regulations has been made to address this.

Systems were in place to ensure that the quality of services provided by the hospital is evaluated on an annual basis and discussed with relevant stakeholders. A clinical and administration audit report is compiled on a quarterly basis and includes information on theatre figures, infection/compliance rates, patient satisfaction, emergency/re-operation audit, incidents, complaints, training and record audits. The MAC meet on a monthly basis and the audit report is discussed within this. Minutes of MAC meetings are retained and were available for inspection.

Policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, dated and systematically reviewed on an annual basis or sooner if required. Staff spoken with were aware of the policies and how to access them.

Arrangements were in place to review risk assessments.

A copy of the complaints procedure was available in the hospital. Staff demonstrated a good awareness of complaints management.

Ms Jordan confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals. During the previous care inspection an area for improvement was made against the standards to develop action plans for each monthly clinical record audit and retain records of the discussions with nursing staff and consultants. No evidence was available to demonstrate that this area for improvement had been met. This area for improvement has been stated for the second time.

Routine audits undertaken include:

- infection prevention and control
- management of waste to include sharps and clinical waste
- intravenous injections
- hand hygiene
- theatre list

A system was in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies as appropriate. A system was also in place to ensure that urgent communications, safety alerts and notices are reviewed and where appropriate, made available to key staff in a timely manner.

The hospital has a policy and procedure in place which outlines the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges.

Three medical practitioner's personnel files were reviewed 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.

There are systems in place to review practising privileges agreements every two years.

Fitzwilliam Clinic has a policy and procedure in place which outlines the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges.

A whistleblowing/raising concerns policy was available. Discussion with staff confirmed that they were aware of who to contact if they had a concern.

Ms Shelia Jordan, registered manager, demonstrated a clear understanding of her role and responsibility in accordance with legislation. Information requested by RQIA has been submitted within specified timeframes. It was confirmed that the statement of purpose and patient's guide are kept under review, revised and updated when necessary and available on request.

The RQIA certificate of registration was up to date and displayed appropriately.

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

Areas of good practice

There were examples of good practice found in relation to management of complaints and incidents and maintaining good working relationships.

Areas for improvement

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, should be carried out. Written reports of the unannounced visits should be available for inspection.

An action plan should be generated for each monthly clinical record audit and actions taken to improve compliance recorded, including details of staff who were spoken with.

	Regulations	Standards
Areas for improvement	1	1

6.8 Equality data

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 Jordan.

7.0 Quality improvement plan (QIP)

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Shelia Jordan, registered manager and the practice 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 further enforcement action including possible prosecution for offences. 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 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.

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 26 **Stated:** First time **To be completed by:** 16 April 2019	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
	Response by registered person detailing the actions taken: Fitzwilliam Clinic have developed a template to provide written report of unannounced visits by one of the registered persons, as outlined in Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005. We ensure that six monthly unannounced visits will be carried out. These written reports will be available for inspection.
Action required to ensure compliance with The Minimum Care Standards for Independent Healthcare Establishments (2014)	
Area for improvement 1 **Ref**: Standard 9.4 **Stated:** Second time **To be completed by:** 16 April 2019	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 who were spoken with. Ref: 6.2 and 6.7
	Response by registered person detailing the actions taken: Quarterly clinical audits will now be monthly. An action plan at end of audit will be completed by manager. The outcome and action plan will be disscussed at nurse meetings and are routinely on the agenda at management meetings
Area for improvement 2 **Ref**: Standard 3.1 **Stated:** First time **To be completed by:** 16 April 2019	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
	Response by registered person detailing the actions taken: Fitzwilliam Clinic have developed a safeguarding children's policy which is in keeping with regional guidence. All staff have read, and signed that they are familiar with the policy.

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