Unannounced Care Inspection Report
29 November 2018

GCRM Belfast

Type of Service: Independent Hospital (IH) – Fertility Services and Assisted Conception
Address: Edgewater House, Edgewater Business Park, Edgewater Road, Belfast, BT3 9JQ
Tel No: 02890781335
Inspectors: Carmel McKeegan, Winifred Maguire and Paul Nixon

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

This is a registered independent hospital that provides fertility services and assisted conception.

3.0 Service details

Organisation/Registered Provider: GCRM Belfast Ltd **Responsible Individual:** Dr Anthony Traub	**Registered Manager:** Ms Donna Tennant
Person in charge at the time of inspection: Dr Anthony Traub	**Date manager registered:** 14 November 2013
Categories of care: Independent Hospital (IH) Prescribed technologies (PT) In vitro Fertilisation (IVT) Private Doctor (PD)	

4.0 Inspection summary

An unannounced inspection took place on 29 November 2018 from 10.00 to 16.45.

RQIA employed a refreshed inspection methodology during this inspection, which has been used successfully in Health and Social Care (HSC) hospitals across Northern Ireland. This methodology will be used to underpin inspections of independent hospitals and hospices in the future.

We would like to thank Dr Traub and all of GCRM Belfast Ltd staff for being welcoming, open and transparent and for providing the inspection team with information and documents they required in a timely manner.

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 team examined various aspects of the establishment in relation to the planning and delivery of services and treatments, the management of medications, complaints management and review of the general oversight of governance across the organisation. The inspection team met with various staff and reviewed relevant records and documentation to support the organisational governance and assurance systems.

We escalated the timing of this inspection due to information recently submitted to RQIA in conjunction with a review of incident notifications, which had been submitted to RQIA. The focus of this inspection was to review the complaints management process, incident notifications, management of medications and the organisation governance and assurance systems.

No immediate concerns were identified in relation to the delivery of services and treatments and patient safety. The inspection team noted areas of strength, particularly in relation to the governance and quality assurance systems in place.

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

Four areas requiring improvement were identified. One area for improvement was made against the regulations to ensure all complainants are informed of the investigative process outcome and the action (if any) that is to be taken, within 28 days of receipt of the complaint.

Three areas of improvement were made against the standards; to ensure all medical practitioners have a practising privileges agreement in place that is reviewed every two years; to ensure that the management of records policies and procedures are updated to include the new patient portal system and to ensure that all complainants are provided with written acknowledgement of their complaint within the time frame in keeping with the establishment's complaints procedure.

The findings of this report will provide the establishment 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	3

This inspection resulted in four areas for improvement being identified. Findings of the inspection were discussed with Dr Anthony Traub, responsible individual; Dr Robbie Kerr, laboratory director; Dr Jim Moohan, consultant and Ms Carly Hanna, general manager, as part of the inspection process and can be found in the main body of the report.

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

4.2 Action/enforcement taken following the most recent care inspection dated 11 December 2017

No further actions were required to be taken following the most recent inspection on 11 December 2017.

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 since the previous care inspection
- the registration status of the establishment
- written and verbal communication received since the previous care inspection
- the previous care inspection report

During the inspection the inspectors met with Dr Anthony Traub, responsible individual, the laboratory director, the general manager, the quality manager, a fertility nurse practitioner, two registered nurses and an administration officer. 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
- safeguarding
- management of patients undergoing fertility treatment
- clinical records
- patient information and decision making
- practising privileges arrangements
- management and governance arrangements

The findings of the inspection were provided to Dr Traub, Dr Kerr, Dr Moohan and the general manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 11 December 2017

The most recent inspection of the establishment was an announced care inspection.

6.2 Review of areas for improvement from the last care inspection dated 11 December 2017

There were no areas for improvement made as a result of the last care 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

Within GCRM Belfast Ltd there is a multi-professional clinical team which includes consultants in reproductive medicine, consultants in obstetrics and gynaecology, a consultant urologist/andrologist, a consultant embryologist, consultant anaesthetists, senior embryologists, trainee embryologists, a fertility nurse practitioner, a team of registered nurses and health care assistants. The clinical team are supported by administration staff, a quality manager, a general manager and a clinic nurse manager.

Discussion with staff members within the establishment, confirmed there are sufficient staff involved in the delivery of services who have evidence of specialist qualifications and skills in fertility treatments to meet the needs of the patients.

Review of records and staff discussion confirmed an induction programme is in place appropriate to the role and arrangements are in place to ensure that staff training and continuing professional development opportunities are available for all staff.

There are rigorous systems in place for undertaking, recording and monitoring all aspects of staff supervision, appraisal and ongoing professional development in keeping with the RQIA training guidance.

A review of four medical practitioners' details confirmed that there was evidence of the following:

- confirmation of identity
- qualifications in line with services provided
- ongoing professional development and continued medical education that meets the requirements of the Royal Colleges and the General Medical Council (GMC)
- an appointed responsible officer
- arrangements for revalidation

However it was identified that the medical practitioner files did not provide verification of their up to date registration with the GMC, current professional indemnity insurance cover or ongoing annual appraisal by a trained medical appraiser. In addition one file did not provide a practising privilege agreement required for that individual.

During the inspection the general manager provided documentary confirmation that all medical practitioners are registered with the GMC. It was confirmed that all medical practitioners are covered under the GCRM Belfast Ltd corporate indemnity insurance. We were advised that the corporate indemnity insurance cover had recently been renewed and the certificate had not yet been received. It was agreed that this would be forwarded to RQIA. On 14 January 2019 RQIA received confirmation by email that all medical practitioners are covered under the GCRM Belfast Ltd corporate indemnity insurance.

All medical practitioners providing services in GCRM Belfast Ltd must have a practising privilege agreement in place outlining their scope of practice, with the exception of the clinical directors who are not under practising privileges agreement but should nonetheless have all the necessary up to date professional documentation in place.

An area of improvement has been made to ensure all medical practitioners have a practising privileges agreement in place and that robust arrangements are established to ensure this is reviewed every two years.

Recruitment and selection

It was confirmed that should staff be recruited robust systems and processes have been developed to ensure that all recruitment documentation as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 is sought and retained for inspection.

GCRM Belfast Ltd is part of The Fertility Partnership (TFP), which is a group of international clinics specialising in assisted conception. During discussion it was indicated that on one occasion, due to unforeseen circumstances, a consultant from another clinic within TFP was required to work in the GCRM Belfast Ltd, inspectors advised that the same recruitment records must be sought and retained in respect of any person recruited to work in the establishment. Assurances were provided during the inspection that this would be implemented with immediate effect.

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

Management of patients undergoing fertility treatment

A range of treatment protocols are in place for the management of patients receiving assisted conception services which have been developed and agreed by all professionals within the establishment.

The protocols for the prevention and management of ovarian hyper stimulation syndrome (OHSS) have been written by the lead clinicians and are evidence based and in line with best practice.

Written protocols are in place for the close monitoring of patients, in order to avoid unnecessary complications including multiple pregnancies.

There is an elective single embryo transfer (e SET) protocol. The e SET protocol sets out the number of embryos that can be placed in a woman in any one cycle and it complies with the Human Fertilisation Embryology Authority (HFEA) Code of Practice.

The protocols and procedures were discussed with the Dr Kerr, laboratory director and the fertility nurse practitioner who demonstrated detailed knowledge on the matter.

Staff outlined the implementation in the establishment of the procedure for indelible labelling of material for individual patients to ensure the unique identification of a patient's material and the checking and recording of all stages of treatment.

Staff confirmed there are daily clinical meetings involving nurses, doctors and members of the embryology team to discuss the management of patients and there are also systems in place to regularly review and discuss patient outcomes. It was confirmed that minutes are retained of all meetings.

Management of medications

Medicines were managed by staff who had been trained and deemed competent to do so. As previously stated an induction process was in place for registered nurses which also included management of medications.

Staff spoken with confirmed that any issues in relation to medicines management were discussed at the monthly staff meetings.

Written policies and standard operating procedures for the management of medicines were up to date and covered all aspects of medicines management within the establishment. These were discussed with the nursing staff, who demonstrated a detailed knowledge on the matter.

A range of treatment protocols was in place. Staff confirmed there were daily clinical meetings involving the medical consultants, registered nurses and members of the embryology team to discuss the management of patients; any recommended changes to treatment plans were discussed and agreed at these meetings. There was also a weekly clinical review meeting at which treatment plans for patients and the medicines being prescribed were agreed and patient outcomes discussed.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available. Medicines were prescribed by the medical consultants. They were normally obtained from a pharmacy supplier in England and then provided to the patients with advice and guidance given on their use. The quantities of medicines prescribed were determined by the establishment's protocols. In certain agreed circumstances medicines were supplied by registered nurses directly from the establishment's stock against a medical consultant signed prescription; for example, top-up prescriptions of fertility medicines or analgesia post procedure. Patient information leaflets were provided with the medicines. On the uncommon occasion that a medicine was not in stock a private prescription, signed by a medical consultant, was issued to the patient.

There was adequate counselling regarding treatment and outcomes and documentation to reflect this. Patients were provided with information regarding their treatment and the medicines prescribed by the medical consultants and registered nurses; this included detailed advice on the purpose of the medicines, how to administer them at home and any potential side effects. This information was given verbally, in paper form and via the establishment's electronic portal. Any changes to treatment were communicated to patients both verbally and through the electronic portal. A 24 hour telephone service/help line was provided by the medical consultants.

The medicine records reviewed were legible and well maintained to ensure that there was a clear audit trail. The electronic portal was used to record information pertaining to treatment.

The establishment had internal arrangements in place to audit all aspects of the management of medicines. Evidence of the activity was maintained. This included a process audit of six randomly selected patient records each month. The organisation could demonstrate if necessary that mechanisms had been put in place to change practice.

There were incident reporting systems in place for identifying, recording, reporting, analysing and learning from adverse incidents and near misses involving medicines and medicinal products. Incidents were discussed at the staff quality meetings and any learning from incidents was discussed at the monthly meetings of registered nurses.

Environment

Due to the focused nature of this inspection, only some communal areas within the premises were reviewed, these areas were maintained to a high standard of maintenance and décor.

Inspectors confirmed that there were secure designated areas, with access by authorised personnel only, for the atmospheric and temperature controlled storage of gamete and embryos.

Areas of good practice

There were examples of good practice found in relation to the control and management of medications and the provision of assisted conception services.

Areas for Improvement

Ensure all medical practitioners have a practising privileges agreement in place and that robust arrangements are established to ensure this is reviewed every two years.

	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.

Clinical records

Patient care records are held electronically, since the previous inspection a patient portal system has been implemented. A staff member demonstrated the patient portal system and three patient's records were reviewed. The patient care records were well documented, contemporaneous and clearly outlined the patient journey.

The care records reviewed contained the following:

- patient registration form
- patient health questionnaire
- pre-operative and post -operative checklists
- intraoperative records
- screening results
- patient treatment plan including medication regime
- copy of the treatment plan schedule which was provided to the patient
- a range of signed consent forms for each procedure
- signed patient contract
- HFEA consent

- record of consultation with the medical practitioner
- embryology records
- follow up letters to patient's GP or referring medical practitioners

Systems are in place to audit the patient care records as outlined in the establishment's quality assurance programme. A number of audits relating to patient care records were reviewed and an excellent compliance rate was noted. It was also confirmed that where the need for improvement was identified that an action plan was implemented and re-auditing would take place.

Information was available for patients on how to access their health records in accordance with the General Data Protection Regulations that came into effect during May 2018 and where appropriate Information Commissioner's Office (ICO) regulations and Freedom of Information legislation.

The establishment is registered with the ICO.

Discussion with staff confirmed they had a good knowledge of effective records management.

The establishment 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. All relevant record management policies and procedures should be updated to include the patient portal system. An area of improvement has been made against the standards in this regard.

The establishment also has a policy and procedure in place for clinical record keeping in relation to patient treatment and care which complies with the General Medical Council (GMC) guidance and Good Medical Practice.

Patient information and decision making

There is written information available for prospective patients regarding the services provided how to access these and costs of treatment. This information is written in plain English and when required is available in an alternative language or format. GCRM Belfast Ltd has a website which provides detailed information for prospective patients on the services provided in the establishment, the website also includes a frequently asked question section relating to wide variety of topics in relation to assisted fertility treatments, including the patient pathway and the potential additional costs of medications.

A patient guide is also available on the website and in the waiting area.

A range of information leaflets on each procedure outlining risks, complications and expected outcomes are available and staff confirmed these are given to patients on consultation.

Discussion with staff confirmed there is procedure on breaking bad news to patients and staff demonstrated a very good understanding of it. Staff stated that they had recently been provided with training in this area.

Patients are aware of who to contact if they want advice or have any issues/concerns and are provided with contact numbers for office hours and out of office hours. Staff confirmed that there is a nurse and a consultant on call during office hours and a consultant is on call out of hours, at all times.

Templates for referral forms and letters to healthcare practitioners have been developed in association with HFEA guidelines.

Staff confirmed there is good communication within each team, management share any learning resulting from complaints, incidents or near misses which is effectively disseminated to staff. Discussion with staff demonstrated good knowledge of the internal management arrangements and all staff spoken with were very aware of their roles and responsibilities.

Areas of good practice

There were examples of good practice found in relation to the management of clinical records, the range and quality of audits and ensuring effective communication between patients and staff.

Areas for improvement

Ensure that the management of records policies and procedures are updated to include the patient portal system.

	Regulations	Standards
Areas for improvement	0	1

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 regarding the consultation and treatment process with senior management and staff confirmed that patients' modesty and dignity is respected. Consultations and treatments are provided within private rooms with the patient and medical practitioner/nursing staff/embryology staff present.

Observations confirmed that patient care records were stored securely, electronic records are password protected and any paper records are held within locked filing cabinets within an area restricted to authorised personnel only. As previously stated a patient portal system had recently been implemented and patients were provided with information on how to operate the patient portal.

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

Patients meet with staff providing the service and are fully involved in decisions regarding their treatment. Discussion with staff and review of patient care records confirmed that patients are treated and cared for in accordance with legislative requirements for equality and rights.

Patients can choose to have their significant other present during consultations and certain treatments; as agreed with staff. Patients' wishes are respected and acknowledged by the establishment. Details of a free independent counselling service are provided to patients. A counselling brochure was available and mandatory counselling is in place for the donor egg/sperm programme.

GCRM Belfast Ltd obtains the views of patients and/or their significant others on a formal and informal basis as an integral part of the service they deliver.

Patients are asked for their comments in relation to the quality of treatment provided, information and care received.

The establishment issued feedback questionnaires to patients on a three monthly basis. The quality manager collates the findings and provides a summary report which is made available to patients and other interested parties. Review of the comments provided by patients indicated a good level of satisfaction with the quality of treatment, information and care received. Some of the comments received included:

- 'We did feel that the staff really care about you and the outcome of your treatment which made things a lot easier. You didn't feel like just another number.'
- 'Doctors and nursing staff excellent.'
- 'All staff were caring and supportive and treated us with the greatest respect while ensuring our privacy. Thank you for a lovely experience.'
- 'All staff were very helpful and friendly. We found them very approachable with any questions.'
- 'The treatment and bedside manner of the nurses was excellent.
- 'Kept me at ease the whole way through, nothing was a problem, any question answered in a way that I understood.'

The information received from all of the patient feedback questionnaires, for the year, is collated into an annual summary report which is made available to patients and other interested parties to read in the waiting area of the establishment.

It was confirmed through discussion that comments received from patients are reviewed by the registered manager and discussed at monthly management meetings. Action is implemented to address any issues identified.

Discussion with staff confirmed that patients and/or their significant others have the opportunity to comment on the quality of care and treatment provided, including their interactions with staff who work within the establishment.

Review of 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.

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 and providing the relevant information to allow patients to make informed choices.

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.

Clinical and Organisational Governance

Prior to the inspection Dr Traub had informed RQIA that he is due to retire from the position of responsible individual and will be replaced by Dr Jim Moohan. In addition Ms Donna Tennent, registered manager, had informed RQIA that she is to become the clinic nurse manager and a registered manager application will be submitted by Ms Carly Hanna, the new general manager, upon completion of her induction process.

During this inspection, senior management outlined the planned changes and realignment of roles internally within the senior management team. Inspectors were able to evidence that there remained a clear organisational structure within the establishment and as previously stated, staff were able to describe their roles and responsibilities and were aware of who to speak with 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 establishment. It was confirmed that Dr Traub, responsible individual, is involved in the day to day running of the establishment and participates in meetings within each department on a weekly basis. The board of directors meet every two weeks where they review the latest key performance indicators and audit findings within the establishment.

Complaints management

A focus of this inspection was the governance and oversight arrangements with respect to the management of complaints.

Discussion with the general manager demonstrated a good awareness of complaints management. A copy of the complaints procedure was available, however inspectors were informed that the complaints procedure was under review and was in the process of being further developed. A copy of the revised complaints procedure was shared with the inspectors, advice and guidance was provided to the general manager in this regard.

A record of complaints was retained which included details of all complaints, communications with the complainants, the result of any investigations, the outcome and the action taken. A tracking system to monitor the complaints management process was recorded in a complaints log. Review of the complaints log evidenced that out of the sixteen complaints recorded since January 2018, a letter acknowledging receipt of the complaint had been issued to 12 complainants within 5 working days, in keeping with in the establishment's complaints procedure. However the complaints log identified that four complainants had not been provided with a letter of acknowledgement. An area of improvement has been made against the standards in this regard.

It was also noted that a written response was provided to twelve complainants within the 20 working day timeframe as stated in the establishment's complaints procedure however there was no record to show that four complainants had received a written response detailing the result of any investigations, the outcome and the action taken.

Discussion with the quality manager and the general manager indicated that they had recognised this shortfall in the complaints management process which had prompted the need to review the complaint procedure. Both managers were receptive to advice provided during the inspection.

An area of improvement has been made against the regulations to ensure that the complainant is informed of the investigative process outcome, action (if any) that is to be taken, within 28 days of receipt of the complaint.

Notifications/incident management

This inspection also focused on the governance and oversight arrangements with respect to the management of clinical adverse incidents. Prior to the inspection RQIA reviewed all notifiable events submitted to RQIA since the previous care inspection which identified that there had been an increase in the number of notifiable events occurring in the establishment. It was confirmed that a system was in place to ensure that notifiable events were investigated and reported to RQIA, HFEA or other relevant bodies as appropriate within a timely manner.

The inspection team noted that medical, nursing and administration staff are identifying incidents and events if/when they occur. Through internal systems, appropriate groups of staff are alerted to the incident or event. The registered manager and clinical directors then assess and consider further actions, as required.

The learning from root cause analysis and subsequent learning from incidents and events was examined. It was evidenced that learning is discussed and recorded in the minutes of senior managers' weekly meetings and a multidisciplinary approach is applied to ensure the dissemination of learning to all staff.

The quality manager outlined the process for analysing incidents and events to detect potential or actual trends or weakness in a particular area in order that a prompt and effective response can be considered by the senior management team at the earliest opportunity. An audit is maintained, reviewed and the findings are presented to the clinical directors during the quarterly management review meetings.

Clinical governance

Arrangements were in place to review risk assessments, a risk management register is maintained and reviewed with the clinical directors on regular basis.

A system was also in place to ensure that urgent communications, safety alerts and notices are reviewed and where appropriate, made available to key staff in a timely manner.

The establishment has arrangements in place to monitor the competency and performance of all staff and report to the relevant professional regulatory bodies in accordance to guidance.

As previously stated the registration status of the health care professionals with their appropriate professional bodies was confirmed during inspection. The general manager confirmed that a system was in place to check registration status of the health care professionals on an annual basis and the registered manager ensures that all health care professionals adhere to their published codes of professional conduct and professional guidelines.

Also as previously discussed an area of improvement has been made to ensure all medical practitioners have a practising privileges agreement in place.

GCRM Belfast Ltd has a policy and procedure in place which outlines the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges. It was confirmed that robust arrangements will be established to ensure this is reviewed every two years.

Staff confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals. If required, an action plan is developed and embedded into practice to address any shortfalls identified during the audit process. The following audits had been undertaken;

- infection prevention and control (IPC) audit
- consent to disclosure audit
- oocyte retrieval audit
- chart file audit
- chart location audit
- patient treatment pathway audit
- supporting process audit
- compliance audit

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

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 spoken with were aware of the policies and how to access them.

Discussion with staff confirmed there are good working relationships. They all spoke positively regarding the establishment, felt valued as members of the team and confirmed they were supported by management.

Dr Traub demonstrated a clear understanding of his 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 governance arrangements, management of incidents, quality improvement and maintaining good working relationships.

Areas for improvement

All complainants should be provided with written acknowledgement of their complaint within the time frame in keeping with the establishment's complaints procedure.

All complainants should be informed of the investigative process, the outcome, and action (if any) that is to be taken, within 28 days of receipt of the complaint.

	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 management and staff.

Total number of areas for improvement

	Regulations	Standards
Total number of areas for improvement	1	3

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Dr Anthony Traub, responsible individual, 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 establishment. 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, 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 23 (4) **Stated:** First time **To be completed by:** 14 February 2019	The registered person shall within 28 days of receipt of a complaint ensure that the complainant is informed of the investigative process outcome and action (if any) that is to be taken. Ref: 6.7 **Response by registered person detailing the actions taken:** All complainants will be contacted within 28 days with the outcome of the complaints investigation and action, if applicable as per the clinic policy.

Action required to ensure compliance with The Minimum Care Standards for Independent Healthcare Establishments (July 2014)	
Area for improvement 1 **Ref**: Standard 11.5 **Stated:** First time **To be completed by:** 14 February 2019	The registered person shall ensure all medical practitioners have a practising privileges agreement in place and that robust arrangements are established to ensure this is reviewed every two years. Ref: 6.3
	Response by registered person detailing the actions taken: All medical practitioners who are not Cinical Directors will be awarded Practising Privileges which will be reviewed every 2 years. This will be recorded on a Excel spreadsheet by the registered manager and monitored on a monthly basis.
Area for improvement 2 **Ref**: Standard 8.2 **Stated:** First time **To be completed by:** 14 February 2019	The registered person shall ensure that the management of records policies and procedures are updated to include the patient portal system. Ref: 6.4
	Response by registered person detailing the actions taken: Revelant policies are currently under review and will be updated and ratified by the responsible personnel within the agreed timescale
Area for improvement 3 **Ref**: Standard 7.1 **Stated:** First time **To be completed by:** 14 February 2019	The registered person shall ensure that the complainant is provided with written acknowledgement of their complaint within the appropriate time frame in keeping with the establishment's complaints procedure. Ref: 6.7
	Response by registered person detailing the actions taken: All complainants will receive a written acknowledgement of their complaint within 3 working days of receipt.

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

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