

Inspection Report

12 December 2024



Newry Private Clinic

Type of service: Independent Hospital (IC) – Day surgery services;
Endoscopy services and Private Doctor
Address: Windsor Avenue, Newry, BT34 1EG
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www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/> [The Independent Health Care Regulations \(Northern Ireland\) 2005](#) and [Minimum Care Standards for Independent Healthcare Establishments \(July 2014\)](#)

1.0 Service information

Organisation/Registered Provider: Windsor Hill Healthcare Limited	Registered Manager: Mrs Laura McCaul
Responsible Individual: Dr David McCaul	Date registered: 22 March 2024
Person in charge at the time of inspection: Mrs Laura McCaul	
Categories of care: Acute Hospital (Day Surgery) – AH (DS) Endoscopy – PT (E) Private Doctor (PD)	
Brief description of how the service operates: Newry Private Clinic is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital with acute hospitals (day surgery only) AH (DS); prescribed techniques or prescribed technology: establishments providing endoscopy services PT(E); and private doctor (PD) categories of care. Newry Private Clinic provides a wide range of services and treatments, including outpatient services across a range of medical specialties; diagnostic tests and investigations. There are no overnight beds in this clinic. The inspection focused solely on those services which fall within regulated activity and the categories of care for which the establishment is registered with RQIA. In August 2024, RQIA were informed by Mrs McCaul that a diagnostic radiology suite was to be built for MRI, X-ray and Ultrasound services in partnership with a private Hospital based in Northern Ireland. This suite will be a direct extension of the current premises and aims to be ready for clinical use by March 2025.	

2.0 Inspection summary

A short notice inspection was undertaken to Newry Private Clinic which commenced with an onsite inspection on 12 December 2024 from 10.00 am to 4.00pm and included a request for the submission of information electronically.

The onsite component of the inspection was completed on 12 December by two care inspectors. Feedback of the onsite inspection findings was delivered to the Newry Private Clinic management team on the day of inspection.

The electronic submission of additional documentation in relation to the premises aspect of the inspection was reviewed remotely by an RQIA estates inspector and feedback was provided to the registered manager following the inspection.

The inspection focussed on four main themes - organisational and clinical governance; staffing arrangements; the management of the patient's care pathway; and estates management.

There was evidence of good practice concerning patient safety in respect of staffing; staff training; safeguarding; infection prevention and control (IPC); and the environment. Other examples included the management of the patients' care pathway; communication; and organisational and clinical governance arrangements.

Additional areas of good practice identified included maintaining patient confidentiality; ensuring the core values of privacy and dignity were upheld; providing the relevant information to allow patients to make informed choices; engagement to enhance the patient experience and estates management.

Two areas for improvement have been identified against the regulations in relation to the recruitment of staff. One area for improvement has been made against the standards in relation to clinical record keeping. These are discussed further in section 5.2.2 and section 5.2.3 respectively.

No concerns were identified in relation to patient safety and the inspection team noted areas of strength in relation to the delivery of care.

3.0 How we inspect

RQIA is required to inspect registered services in accordance with legislation. To do this, we gather and review the information we hold about the service, examine a variety of relevant records, meet and talk with staff and management and observe practices on the day of the inspection.

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

- Notifiable events since the previous care inspection
- The registration status of the clinic
- Written and verbal communication received since the previous care inspection
- The previous care inspection reports and quality improvement plan (QIP)

One week prior to the onsite aspect of the inspection, the clinic was provided with a list of specific documents requesting items to be reviewed remotely in respect of the maintenance of the premises and grounds. These items were to be sent electronically to our estates inspector on or before 16th December 2024 for review remotely.

The information obtained was then considered before a determination was made on whether the establishment is operating in accordance with the relevant legislation and minimum standards.

During the inspection we spoke with Mrs McCaul, the Clinic Manager, the Quality Assurance Manager, and a theatre nurse.

Examples of good practice are acknowledged and any areas for improvement are discussed with the person in charge and detailed in the QIP.

4.0 What people told us about the service

Posters were issued to Newry Clinic by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire. No completed patients or staff questionnaires were submitted to RQIA prior to the inspection.

Through discussion with a number of staff who have differing roles and responsibilities, it was determined that staffing levels and morale were good with evidence of good multi-disciplinary team working and effective communication between staff.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to Newry Private Clinic was undertaken on 5 and 6 March 2024; no areas for improvement were identified.

5.2 Inspection outcome

5.2.1 Governance and Leadership

Organisational Governance

As previously stated Newry Private Clinic is operated by Windsor Hill Healthcare Limited. Dr McCaul and Mrs McCaul are directors of Windsor Hill Healthcare Limited. The management team is composed of Mrs McCaul, who is the Clinic Director and responsible for day to day management. She is supported by both a practice manager and a clinical services manager who oversee administration, staffing and quality assurance matters.

Various aspects of the organisational system were discussed with the management team.

The management team described an effective governance structure that provides a process and system of accountability to support the delivery of good quality service and to monitor and maintain high standards of care.

It was evidenced that medical advisory committee (MAC) is well established and its meetings take place on a quarterly basis in line with Standard 30 of the minimum standards. The MAC is attended by Dr McCaul, who acts as chair; Mrs McCaul, the clinical services manager, the clinic manager, nurse manager and a surgeon.

Minutes of MAC meetings were retained and available for inspection. The minutes reviewed evidenced that standing agenda items were included such as risk management, audits, clinical incidents and complaints, feedback on the patient experience and staff management, including the granting and renewal of practicing privileges. Action plans were recorded including their respective process owners.

It was confirmed that the senior management team (SMT) meet on a six-weekly basis and these meetings are attended by Mrs McCaul, the clinical services manager, the clinic manager and the accounts manager. Staffing, professional registration status, training compliance, performance indicators and service development matters are discussed and escalated to the MAC where relevant.

As previously mentioned, Mrs McCaul is the registered manager and is in day to day management of the clinic. Mrs McCaul reports directly to Dr McCaul, the responsible individual, who as Mrs McCaul confirmed, remains in daily contact with the clinic and maintains oversight of service delivery. Therefore, Regulation 26 unannounced quality monitoring visits do not apply.

Patient consultation was discussed with Mrs McCaul. Patients are provided with the opportunity to complete a satisfaction survey. The most recent survey results had been summarised into a report, dated November 2024, and a review of this found that patients were very satisfied with the quality of treatment, information and care received.

Policies and procedures are ratified by the MAC and are available on desktop for staff reference. There is a system of document control and review in place. Staff were aware of these policies and how to access them.

Examination of insurance documentation confirmed that insurance policies were in place.

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

Mrs McCaul described an effective governance structure that provides a process and system of accountability to support the delivery of good quality service and high standards of care.

Clinical and Medical Governance

A team of consultants and surgeons with specialist qualifications work at the clinic. During the inspection, it was confirmed that two of the consultants were considered to be wholly private doctors as they are no longer affiliated with the Health and Social Care (HSC) sector in Northern Ireland (NI) and are not on the general practitioners (GP) performers list in NI.

A review of both private doctors' personnel files confirmed there was evidence of the following:

- Conformation of Identity
- Current General Medical Council (GMC) registration
- Professional indemnity insurance
- Qualifications in line with service provided

- Ongoing annual appraisal by a trained medical appraiser
- Each consultant had an appointed responsible officer (RO)

We reviewed the arrangements for the oversight and recording of mandatory training, appraisal and revalidation in accordance with best practice guidance. The clinic retains a copy of the consultant's annual appraisal document. Appraisal is a key component of revalidation and the consultant must provide evidence of CPD in accordance with GMC's Good Medical Practice in support of their revalidation. The clinical services manager maintains an up to date log of a consultant's appraisal status, the reasons for any delays, the decisions made and the time bound actions taken or any associated follow-up required for continued practicing privileges to be granted.

All medical practitioners working in the establishment must have a designated RO and, in accordance with the GMC, all doctors must revalidate every 5 years. The clinical services manager is responsible for matters relating to medical practitioners at the clinic. It was evidenced that there are systems in place for the clinical services manager to monitor professional indemnity, professional registration and revalidation with the GMC for all medical practitioners at the clinic.

A training matrix was available in respect of all medical practitioners working at the clinic. We reviewed the ongoing professional development and continued medical education in respect of both private doctors and it was identified that they had either completed or were in the process of undertaking external training courses in line with the [RQIA training guidance](#).

Practicing Privileges

The only mechanism for a medical practitioner to work in a registered independent hospital is either under a practicing privileges agreement or through direct employment by the hospital. Mrs McCaul informed us that medical practitioners who work at Newry Private Clinic work under a practicing privileges agreement

A detailed policy and procedure for the granting, review and withdrawal of practicing privileges agreements was in place.

A sample of medical practitioner records were reviewed. It was evidenced that there was a practicing privileges agreement between each private doctor and Newry Private Clinic and these were being reviewed every two years. The terms and conditions were clearly stated along with their scope of practice and the agreements had been signed by both parties.

Discussion with the clinical services manager and a review of the policy confirmed that there were clear requirements on the timeframes for when annual appraisals should be submitted to the clinic.

As previously discussed, any matters relating to the granting or renewing of practicing privileges are discussed and resolved during quarterly or, when required, ad-hoc meetings the MAC.

It is determined that good oversight arrangements for the granting and reviewing of practicing privileges were in place.

Quality Assurance

The arrangements in place to monitor, audit and review the effectiveness and quality of care and treatment were reviewed.

Systems were in place to ensure that the quality of services provided by the clinic is evaluated on an ongoing basis. A quality improvement schedule had been devised and implemented during each quarter of 2024.

It was evidenced that a clinical audit had been undertaken as part of gynaecology service at the clinic. A review of this audit evidenced that arrangements were in place to review the results, actions and recommendations of audit through the clinic's governance structures. Discussion with Mrs McCaul confirmed that the senior management team were keen to implement a regular clinical audit programme.

Audit planning was discussed with the management team. Mrs McCaul confirmed that an internal audit schedule was in development for the year ahead with an aim to monitor compliance with clinic policies and processes. A new audit tracking tool was shared with RQIA, to demonstrate how the senior management team intends to monitor, manage and document auditing issues.

Advice and guidance was provided to the management team regarding an audit programme and the establishment of key performance indicators (KPIs) to further strengthen ongoing quality assurance and safety of the services provided.

Arrangements were 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 identified that systems were in place to support good risk management within the clinic. This ensures that the likelihood of adverse incidents, risks and complaints are minimised by effective identification, prioritisation, treatment and management.

Risks were documented, collated and tracked through the use of a risk register which provided assurance about the effective identification and management of risk.

The clinic is working towards participation in the Private Healthcare Information Network (PHIN), which will assist in benchmarking the safety and quality of their service against similar services across the UK.

Overall the governance structures within the clinic provided the required level of assurance to the responsible individual and senior management team at Newry Private Clinic.

Notifiable Events/Incidents

A policy for the management and reporting of clinical risks, incidents and near misses and a policy for the management of national safety alerts was in place.

The management team confirmed that any learning from incidents would be discussed with staff groups to drive improvement in the quality of the service. There was a process in place for analysing incidents and events to detect potential or actual trends or weaknesses in a particular

area, in order that a prompt and effective response can be considered at the earliest opportunity.

Significant incidents and themes reported are discussed at the organisation's SMT meetings, the MAC and team meetings.

Advice and guidance was provided to the management team regarding the arrangements for reporting notifiable incidents to RQIA. Mrs McCaul gave assurances that relevant incidents would be reported to RQIA in accordance with legislation and RQIA's [Statutory Notification of Incidents and Deaths](#).

Complaints Managements

A copy of the complaints procedure is made available for patients/and or their representatives on request and staff demonstrated a good awareness of complaints management.

A review of the complaints log confirmed that all complaints received had been investigated and responded to appropriately to include details of communications with complainants; the result of any investigation; the outcome and any action taken. An audit of complaints since the previous inspection was available to review. Mrs McCaul and the clinic services manager gave assurances that any themes emerging from complaints would be analysed and recorded along with any actions taken. It was evidenced that complaints are a standing item on the MAC agenda.

Learning from complaints is shared across staff groups to drive improvement in the quality of the service.

5.2.2 Does the clinic have appropriately qualified and skilled staff in place?

The staffing arrangements in respect of Newry Private Clinic were reviewed.

A staff register was available to review and was found to be up to date and contained staff details in keeping with legislation.

A review of duty rotas and discussion with staff evidenced that there were sufficient staff in various roles to fulfil the needs of the clinic and patients.

A recruitment policy and procedure was in place. Advice and guidance was provided to Mrs McCaul, who is responsible for recruitment at the clinic, to further develop this policy to ensure it is line with legislation and best practice guidance. Following inspection, RQIA received evidence that this matter had been addressed.

Discussion with Mrs McCaul confirmed that new staff members had been recruited since the previous inspection. The personnel files of these newly recruited staff were reviewed.

It was identified that not all information as listed in Regulation 19, Schedule 2 of the Independent Health Care regulations (NI) 2005 had been sought and retained, in respect of one private doctor, prior to the start of their employment. This was brought to the attention of Mrs McCaul and the clinical services manager. An area for improvement against the regulations has been made in this regard.

AccessNI disclosure checks had been completed prior to commencement of employment in respect of the new staff members, however it was identified that a basic check had been applied for as opposed to the required enhanced checks. This was discussed with Mrs McCaul and an area for improvement against the regulations has been made in this regard.

Advice and guidance was provided to Mrs McCaul to ensure that all recruitment documentation as outlined in Regulation 19, Schedule 2 of the Independent Health Care regulations (NI) 2005 is sought and retained for any new staff member in future.

A structured induction programme and orientation, relevant to roles and responsibilities, was available for newly recruited staff. Records of completed induction had been retained in personnel files. It was evidenced that appraisals had been completed on an annual basis and staff reported that they were well supported and that there were good working relationships throughout the clinic. We found clear evidence of multi-disciplinary working.

All staff working in Newry Private Clinic, whether employed directly or under practicing privileges agreements, must complete training in keeping with [RQIA training guidance](#) and their professional regulatory body.

Training matrices were in place to record the status of staff training and it was noted that this included medical staff who work under practicing privileges agreements. The respective training matrices are overseen by the practice manager and the clinical services manager for administration and clinical staff respectively.

Training files of three clinical staff employed by the clinic were reviewed and it was identified that mandatory training certificates were not available in respect of basic life support, safeguarding adults at risk of harm and fire safety. This was brought to the attention of the Mrs McCaul and the clinical services manager. Following inspection, RQIA received evidence that the relevant training had since been undertaken by the clinical staff in question and that certificates had been retained in individual files.

Robust arrangements were in place to check the registration status for all clinical staff on an ongoing basis. The arrangement for monitoring the professional indemnity of relevant staff was also in place.

Addressing the areas for improvement as outlined above will ensure that recruitment of staff in future will comply with legislation and best practice guidance.

5.2.3 Are there safe practices in place for the day surgery/ endoscopy?

We reviewed the arrangements for the provision of day surgery and endoscopy services in the hospital outlined under their statement of purpose and categories of care. The review of day surgery and endoscopy arrangements evidenced that the service will operate in accordance with best practice and national standards to ensure care delivery is safe and effective.

The scheduling of patients for day surgery or endoscopy procedures is co-ordinated by hospital management with the involvement of the consultant and senior nursing staff. Scheduling takes into account individual patient requirements, staffing levels, the nature of the procedure and any associated risks.

The patient is sent information about the procedure and any preparation necessary in advance, together with the consent form.

The consent process is completed by the consultant carrying out the procedure as part of the admission process. The consented patient is then escorted to the treatment/endoscopy room.

There is an identified member of nursing staff, with relevant experience, in charge during all procedures. Staff complete a surgical safety checklist based on World Health Organisation (WHO) guidance and completion of the surgical checklist and compliance will be routinely audited through the hospital's auditing process.

It was confirmed that patients are observed during and after the procedure by appropriately trained staff. Patients are discharged in accordance to discharge criteria by the nursing staff. However, this was not fully reflected in the standard operating procedure (SOP) or the patient care pathway record and it was advised to amend the SOP and patient care pathway record. Following inspection, RQIA received evidence that this matter had been addressed.

It was confirmed that if there were any concerns about the patient's condition, the consultant would be immediately informed for ongoing management. Patients are provided with clear, post procedure advice information on follow up and who to contact in the event of a post treatment emergency.

Surgical/endoscopy register is maintained for all procedures undertaken in the hospital. It was advised to ensure the traceability details (stickers/labels) of medical devices used for individual patients are included in the register.

Five completed endoscopy patient care pathway records were reviewed. They were found to be largely well completed and most included details of the record of admission, medical history, IPC status, medication, observations on admission, pre-procedure checklist, surgical safety checklist (WHO), intra- procedure details.

It was noted that two different care pathway records had been used. However only one had been ratified by the MAC and therefore approved for use. The other care pathway record was less detailed. All care pathway records did not have the following included the date of procedure, traceability details (sticker/label) of medical devices used, record of pre-procedure urinalysis (as outlined in standard operating procedure), record of any irrigation fluid used and a detailed discharge record. An area of improvement has been identified against the standards to ensure all treatment and care is recorded in the patient clinical record.

There were procedures for the management of specimens. However, they did not fully reflect all details relating to the collection, labelling, storage, preservation, transport and administration of specimens. Advice was provided to ensure that a separate specimen log is established for specimens obtained during endoscopy or surgical procedures ensuring checking includes signed witnessing by two staff and the final check by the consultant. Following inspection, RQIA received evidence that this matter had been addressed. It was confirmed there is a contract in place with a pathology laboratory service. It was advised to ensure the pathology services are subject to internal audit.

It was confirmed that endoscopy and surgical equipment are all single use.

It was determined that the implementation of the areas of improvement identified will consolidate safe and effective day surgery and endoscopy services.

5.2.4 Estates

Documentation in relation to the maintenance of the premises, including the mechanical and electrical services was submitted for review. These demonstrated that suitable arrangements are in place for maintaining the environment in accordance with current legislation and best practice guidance.

The premises specialised ventilation systems and medical gas pipeline services, continue to be serviced and maintained in accordance with current best practice guidance. Suitable validation is undertaken in accordance with the current Health Technical Memoranda.

A current Legionella Risk Assessment was in place and suitable control measures for the premises hot and cold water systems were being undertaken with appropriate records being maintained. Regular bacteriological sampling of the hot and cold water systems is also undertaken and appropriate action is taken when necessary.

The Fire Risk Assessment continues to be reviewed by a suitably accredited fire risk assessor. The overall assessment of the risk assessment was assessed as 'tolerable' and the significant findings had been suitably addressed. The most recent fire drill for the premises was undertaken in July 2024.

No areas for improvement in relation to estates management were identified as a result of this inspection.

6.0 Quality Improvement Plan/Areas for Improvement

Three areas for improvement has been identified where action is required to ensure compliance with [The Independent Health Care Regulations \(Northern Ireland\) 2005](#) and the [Minimum care standards for independent healthcare establishments \(July 2014\)](#)

	Regulations	Standards
Total number of Areas for Improvement	2	1

Findings of the inspection were discussed with Mrs McCaul, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan from the 2024 Inspection

Action required to ensure compliance with [The Independent Health Care Regulations \(Northern Ireland\) 2005](#)

<p>Area for improvement 1</p> <p>Ref: Standard 19 (2) Schedule 2, as amended</p> <p>Stated: First Time</p> <p>To be completed by: 12 December 2024</p>	<p>The responsible persons shall ensure that an AccessNI enhanced disclosure check is completed and the outcome recorded for any relevant person who is to commence employment at Newry Private Clinic.</p>
	<p>Action taken as confirmed during the inspection: Newry Private Clinic is now registered with an Umbrella body and the majority of Admin and Clinical Staff have now completed there AccessNI enhanced disclosure check and the outcomes of these have been recorded. This improvement was relevant for all existing staff and is now part of the Practising Privileges and induction for all staff commencing at the Newry Private Clinic.</p>

<p>Area for improvement 2</p> <p>Ref: Regulation 19 (2) (d) as amended</p> <p>Stated: First Time</p> <p>To be completed by: 12 December 2024</p>	<p>The responsible persons shall ensure that all required recruitment records are in place prior to the commencement of employment for any staff; or any private doctor or consultant medical practitioner providing services under practising privileges.</p>
	<p>Action taken as confirmed during the inspection: The Practising Priviledges policy and the Induction Checklist has been revised to ensure that all required information as listed in Regulation 19, Schedule 2 of the Independent Health Care Regulations (NI) 2005 is sought and retained before any clinician can commence practising at the Newry Private Clinic.</p>

Action required to ensure compliance with the [Minimum care standards for independent healthcare establishments \(July 2014\)](#)

<p>Area for improvement 1</p> <p>Ref: standard 6.7</p> <p>Stated: First</p> <p>To be completed by: 12 December 2024</p>	<p>The responsible persons shall ensure all treatment and care is recorded in the patient clinical record.</p>
	<p>Action taken as confirmed during the inspection: As was noted during the inspection there were two different care pathways used for procedures. The 'obselete' care pathway has now been deleted from all systems and paper copies destroyed and the Care Pathway that had been ratified by MAC is now in place.</p> <p>An informal feedback session from the inspection was held with the nursing staff on 16th December during this session the approved care pathways were shared and it was discussed of the importance of detailed recording for the patient procedure. We then had a formal training session for all nursing and health care staff held on 20th January 2025 and all this information was explained and importance stressed for good record keeping.</p>

	<p>The Quality Assurance Manager has checked the one patient who has had a procedure since the inspection and is satisfied all the paperwork is in order. An audit of all patient pathways is listed as one of the audits that will be undertaken once there is enough to audit, but in the meantime the Quality Assurance Manager will continue to monitor.</p>
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