The Regulation and Quality Improvement Authority

Inspection Report

10 and 11 September 2025

Kingsbridge Private Hospital

Type of service: Independent Hospital
Address: 811-815 Lisburn Road, Belfast, BT9 7GX
Telephone number: 028 9066 7878

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

1.0 Service information

Organisation/Registered Provider: Kingsbridge Healthcare Group Limited **Responsible Individual:** Mr Mark Regan	**Registered Manager:** Ms Kelly Macartney **Date registered:** 14 September 2022
Person in charge at the time of inspection: Ms Kelly Macartney	**Number of registered places:** 36 Inpatient beds (inclusive of two critical care beds) 12 Day surgery beds
Categories of care: Independent Hospital (IH) Acute Hospital Inpatient (AH) Acute Hospital Day surgery (AH(DS) Private Doctors (PD) Prescribed Technologies (PT) Endoscopy PT(E)	
Brief description of the accommodation/how the service operates: Kingsbridge Private Hospital (KPH) provides a wide range of surgical, medical and outpatient services for both adults and children. The hospital is registered to accommodate up to 36 patients as in-patients and 12 day surgery beds. The hospital has four theatres, one of which is a fully functioning laminar flow theatre, along with recovery units; a dedicated endoscopy suite; an x-ray department and a range of consulting rooms. The in-patient and day surgery accommodation comprises single en-suite rooms which are situated over two floors. The hospital also offers cardiac surgery procedures and has two critical care beds for the provision of post-cardiac surgery critical care as required. Kingsbridge Healthcare Group Limited is the registered provider for three independent hospitals registered with RQIA. Mr Mark Regan is the responsible individual for Kingsbridge Healthcare Group Limited.	

2.0 Inspection summary

A short notice announced inspection was undertaken to the KPH on 10 and 11 September 2025 and included a request for the submission of information electronically.

The onsite care component of the inspection was undertaken by one senior inspector, four care inspectors and an ADEPT (Achieve Develop Explore Programme for Trainees) Fellow on 10 and 11 September 2025.

The ADEPT fellowship provides senior doctors in training with an opportunity to take time off their medical training for one year and work in an apprenticeship model with senior leaders in host organisations across Northern Ireland in order to develop organisation and leadership skills.

This inspection focused on five main key themes: organisational and clinical governance; staffing arrangements; the management of cardiac surgery patients' care pathway; the management of the general surgery patients' care pathway and estates management.

Examples of good practice were evidenced in patient safety in respect of the management of the patients' care pathway and engagement to enhance the patients' experience.

No concerns were identified in relation to patient safety and the inspection team noted areas of strength, particularly in relation to the delivery of front line 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 days of the inspection.

Prior to the inspection we reviewed a range of information relevant to the hospital. 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 inspection team undertook a tour of the premises and the inspection was facilitated by Ms Macartney and other staff members.

The inspection team spoke with; Mr Regan; Ms Macartney; the medical director; the clinical governance manager, the theatre manager; a deputy theatre sister; a theatre nurse (cardiac scrub nurse), post anaesthesia care unit (PACU) manager, clinical nurse educator (cardiac services/intensive care unit), the residential medical officer; the inpatient unit ward sister, two inpatient unit deputy sisters; ward based nursing staff caring for pre and post-operative patients, the infection prevention and control (IPC) lead nurse and members of the hospital liaison team.

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

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 KPH by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire.

No patients submitted responses.

One staff member submitted a questionnaire response. The respondent indicated that patients were treated with compassion and indicated a level of dissatisfaction with regards to the service being well led. The staff member did not indicate satisfaction nor dissatisfaction with regards to the effectiveness or safety of patient care. The respondent commented that they found it challenging to maintain critical care skills as they are not regularly caring for critical care patients. The respondent suggested that technical support training would be useful to keep skills up to date.

As outlined in the previous section, the inspection team spoke with a wide range of staff across the hospital. Overall the feedback from staff spoken with was positive.

5.0 The inspection

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

Areas for improvement from the last inspection on 15 May 2023		
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 16 **Stated:** First time	The responsible individual shall appoint an external independent organisation or human resource advisor to undertake a cultural assessment of the hospital. An action plan should be generated to address any recommendations within the report detailing the main findings of the cultural assessment.	**Met**

	Action taken as confirmed during the inspection: This area for improvement has been assessed as met and further detail is provided in section.5.2.1	

5.2 Inspection findings

5.2.1 Governance and Leadership

Organisational Governance

Various aspects of the organisational and medical governance systems were reviewed and evidenced a clear organisational structure within KPH.

As previously outlined, Mr Regan is the responsible individual for the Kingsbridge Healthcare Group Limited which has three independent hospitals registered with RQIA. Ms Macartney, registered manager, is the nominated individual with overall responsibility for the day to day operational management of KPH. Mr Regan confirmed that he has regular contact with Ms Macartney and is frequently present in the establishment.

KPH is part of the Kingsbridge Healthcare Group (KHG) and is supported by established corporate governance arrangements as detailed in the KPG's 'Governance and Compliance Strategy and Framework' and is underpinned by five quality improvement strands as outlined in the Quality Improvement Strategy 2025. This includes a range of quality and governance meetings at KHG Board and at local hospital levels. These meetings are attended by representatives from the senior management team, clinical leads, and general managers with a view to ensuring the efficient and effective flow of information throughout the organisation. Each group has a set agenda reflective of its specific remit. Quality and governance groups include:

- Monthly meeting of the Local Governance and Quality Team (LGQT) and the Intensive care unit (ICU) Governance and Quality Team;
- Quarterly meeting of the KHG Administrative and Quality Team (GAQT); (inclusive of estates, finance, procurement, human resources, operations and contracts)
- Quarterly meeting of the KHG Medical Advisory Committee (MAC) meeting;
- Weekly meeting of the local hospital management team (LMT).

Separate quality and governance teams are in place for compliance and risk, information technology (IT), infection prevention and control (IPC) and estates.

The KHG have further developed their corporate governance arrangements with the introduction of a centralised governance team led by a new group head of corporate governance. In addition, a group clinical governance manager has been appointed. The head of corporate governance and clinical governance manager prepare a quarterly analytical report for the MAC focusing on risk, incident rates and trend analysis.

Further development with regards to centralised corporate governance includes the development of safety and governance practitioners who have a focus on incident and compliance management and quality assurance practitioners. These are hybrid roles with a clinical governance and patient experience focus.

The clinical governance manager provided an overview of the newly implemented staff Quality Portal which had recently gone live across KHG.

The Quality Portal provides staff with access to; patient feedback analysis; a learning pool and training modules with 'byte size' learning inputs; an IPC newsletter and shared learning updates; wellbeing and support resources, and also quality and compliance information including minutes of the LQGT meetings. The inspection team were informed that staff feedback will be sought on the content and format of the Quality Portal which will influence further development based on staff requirements. The development of the Quality Portal was identified as an area of good practice.

Discussion with Ms Macartney, members of the staff team and review of corresponding documentation, including the minutes of staff meetings, confirmed that KHG had undertaken a staff cultural review and developed a corresponding action plan based on the findings of the review. Documentation reviewed during the inspection evidenced the progression of the action plan, which included the implementation of the Quality Portal and its ongoing review. It was determined that the previous area for improvement 1, made against the standards, as outlined in section 5.1. has been met.

We spoke with members of the KPH management and governance teams who described an effective organisational and governance structure. The system described to RQIA demonstrated clear lines of accountability are in place to support the delivery of quality services and allows managers to monitor and maintain high standards of care.

A range of minutes from governance and quality meetings were made available for review.

Risk management procedures and arrangements for the oversight and management of incidents were reviewed and provided assurance that risks identified with the hospital, including treatment and services provided are identified, assessed and managed appropriately.

The Competition and Markets Authority (CMA) requires that all hospitals and consultants offering private treatment submit data to the Private Healthcare Information Network (PHIN) as the Information Organisation for private healthcare. This provides people considering private healthcare with clear information to help them make an informed choice of which consultant and hospital is right for them.

We were informed that an electronic system for receiving patient experience feedback has been implemented which enables the KHG to feed into PHIN. The clinical governance manager outlined how the newly implemented safety and governance practitioner positions will have responsibility for oversight and submission of PHIN data for the KHG.

Discussion with the clinical governance manager and Ms Macartney informed us that KHG has begun to acquire a variety of patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) to assess the effectiveness of care and treatment experienced by patients.

The newly established quality assurance roles, as outlined above, will hold a remit for review and analysis of PREMS and PROMS, as well as corresponding audit, data analysis and patient voices. PROMS and PREMS, as well as patient feedback will be featured monthly on the newly established Quality Portal which as previously stated, is accessible to all KHG staff.

There was also evidence of patient feedback being shared with staff as a means of continually evaluating and driving service improvement. Patient feedback, PROMS and PREMS will now be shared with staff via the Quality Portal.

It was confirmed by the clinical governance manager that arrangements are in place to make follow up contact with any patient who expresses a level of dissatisfaction with the quality of service or treatment provided.

A range of policies and procedures were accessible. Policies and procedures examined were in date with a planned review date recorded and they were retained in a way that is easily accessible to all staff.

Discussion with staff and a review of records evidenced that staff meetings take place every month and minutes were available to review.

Clinical and medical governance

A team of consultants with specialist qualifications and resident medical officers (RMOs) work at KPH.

The KHG Board of Directors (the Board) requires consultant medical practitioners to practice in accordance with the General Medical Council (GMC) guidance 'Good Medical Practice', completing appropriate appraisal and revalidation requirements and adhering to the KHG practising privileges agreement.

The medical director provides medical leadership and has overall responsibility for the delivery of the clinical governance framework.

There is a robust mechanism for reporting and recording of all clinical incidents; to regularly review all such incidents; consider issues of concern or complaint relating to the clinical practice of an individual where identified; and to bring to the attention of the medical director and the MAC for review and consideration.

As previously outlined the MAC operates at group level and meets quarterly with responsibility for surgeon performance and surgery specific matters. Terms of reference for the MAC were in place and these have been developed in accordance with Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments (2014). It was evidenced that the MAC meetings have standing agenda items and are used as a forum to discuss clinical governance issues; the appointment and renewal of practising privileges agreements; the review of performance indicators; corrective action in relation to adverse clinical incidents; and any other untoward event or near miss. A review of MAC meeting minutes confirmed that these meetings were being undertaken on a quarterly basis in line with the criteria set out in Standard 30.

In accordance with the requirements of registration with the GMC, all doctors must revalidate every five years.

The revalidation process requires doctors to collect examples of their work to understand what they are doing well and how they can improve.

Experienced senior doctors work as Responsible Officers (ROs) with the GMC to make sure doctors are reviewing their work. As part of the revalidation process, ROs make a revalidation recommendation to the GMC. It was established that KHG is registered with the GMC as a designated body and have an appointed RO.

A number of consultants are considered to be wholly private doctors as they are GMC registered doctor who do not have a prescribed connection to a Responsible Officer within the Health and Social Care (HSC) sector in Northern Ireland.

A review of a sample of three private consultants' details confirmed evidence of the following:

- confirmation of identity
- current GMC registration
- professional indemnity insurance
- qualifications in line with service provided
- ongoing professional development and continued medical education that meets the requirements of the Royal Colleges and the GMC
- ongoing annual appraisal by a trained Medical Appraiser
- an appointed RO
- arrangements for revalidation

Appraisal is a key part of revalidation and includes the appraisee providing evidence of their individual continuing professional development (CPD) activities undertaken in accordance with the GMC Good Medical Practice.

The medical director informed us that KHG has implemented an online portal to enable consultants to submit their annual appraisal documentation. This provides an accurate and up to date position on each consultant's appraisal status which clearly evidences any delay. This provides the medical director and the MAC oversight of the status of all individual consultant's medical appraisals.

The arrangements for oversight and recording of mandatory training and professional development activities in accordance with best practice guidance was discussed with the medical director and Ms Macartney. It was confirmed that there is an expectation of all consultants, working under practicing privileges, to provide evidence of mandatory training. A review of consultant files confirmed that certificates of mandatory training are retained on file.

Discussion with Ms Macartney and review of records demonstrated that training compliance rates are subject to ongoing audit and monitoring at monthly and quarterly intervals and are also included in the quarterly LGQT and MAC meetings. Review of the most recent report detailing compliance rates for medical staff training confirmed that a high percentage of medical staff have completed or have scheduled dates to undertake mandatory training.
In KPH clinical audit is managed by individual departments and clinical specialities. KPH has a rolling programme of key clinical audits and individual audits are also undertaken by clinical staff. Consultants are encouraged to complete one clinical audit per year.

Audits available for review included critical care; augmented care IPC; speciality audits for ear nose throat (ENT); gynaecology; urology and plastic surgery specialisms; physiotherapy; and caseload audits evaluating service delivery. In addition a quarterly independent IPC environmental and clinical practice audit is also undertaken. Audits reviewed identified key learning points and stated recommendations for improvement. A tracker was in place to log and manage actions through to completion.

The clinical governance manager told us that a new Harmony Audit Portal will be introduced which will enable a KHG wide approach to auditing and benchmarking.

It was confirmed that audit findings, including IPC audit findings, are shared at local and group quality governance meetings and at the IPC steering group meetings.

Practising Privileges

The only mechanism for a medical practitioner to work in a registered independent hospital is, either under a practising privileges agreement or, through direct employment by the hospital.

Practicing privileges can only be granted or renewed when full and satisfactory information has been sought and retained in respect of each of the records specified in Regulation 19 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended.

A policy and procedure for the granting, review and withdrawal of practicing privileges agreements was not available for review. We were advised by Mrs Macartney that this document is undergoing revision and is awaiting ratification by the MAC.

A review of a sample of records evidenced that there was an agreement between each private doctor and KHG, which sets out terms and conditions.

Review of minutes demonstrated that practicing privileges matters, including the restriction/suspension of privileges, are discussed and reviewed during MAC meetings.

The MAC has agreed the timeframe during which annual appraisals should be submitted, and discussion with the medical director confirmed the actions to be taken if annual appraisals are not submitted by the deadline. It was confirmed that there is a now a requirement to demonstrate completion of specific areas of mandatory training, in addition to having professional indemnity and Information Commissioner's Office (ICO) registration in place to enable approval of a practising privileges application.

As mentioned previously, an online platform has been implemented which also facilitates consultants to electronically submit all required documentation required for a practising privileges application and renewals. This electronic system has a tracking capability to issue reminders and other communications to consultants in addition to providing oversight to senior management.

The medical director stated that the platform has facilitated clinician engagement and improved the process for reviewing and granting practicing privileges, reviewing scope of practice and monitoring compliance.

Good oversight arrangements of the granting of practicing privileges agreements were in place and provided assurance of robust medical governance arrangements within the organisation.

Quality assurance

Arrangements were in place to monitor, audit and review the effectiveness and quality of care and treatment delivered to patients at appropriate intervals.

Significant incidents and themes reported are discussed during the LMT, LGCT and MAC meetings.

There was a robust programme for internal audit to monitor compliance with policies and processes. Audits are completed monthly, quarterly and annually as per the KHG's audit schedule. If required, an action plan is developed to address any shortfalls identified during the audit process.

It was demonstrated that 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.

Notifiable Events/Incidents

The Governance and Compliance Strategy and Framework provides an overview of the mechanisms in place, and of roles and responsibilities at all levels throughout KHG, to oversee, report and respond to clinical risks, incidents and near misses. This includes reporting requirements to external bodies as required and the arrangements for the management of national safety alerts. The Adverse Incident Policy further describes the internal electronic reporting mechanism, which is accessible to all staff, and corresponding investigation pathways following categorisation of the incident.

Review of meeting minutes and discussion with the management team confirmed that any learning from incidents would be cascaded to relevant staff members.

There was a process in place 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 at the earliest opportunity.

As previously mentioned significant incidents and themes reported are discussed at the organisation's clinical governance meetings, the MAC and health and safety committees.

Complaints Management

A copy of the KPH complaints policy was available for review and was found to be in line with relevant legislation and Department of Health (DoH) guidance on complaints handling.

Review of the complaints log confirmed that all complaints received in the previous 12 months were investigated and responded to in line with the complaints policy. Details of all communications with complainants; any investigation undertaken and the resultant actions were documented. Any learning from the investigation of complaints is disseminated across all staff groups to drive improvement in the quality of the service.

A recent complaints audit completed was available for review during the inspection. The audit was up to date and capable of reflecting any themes emerging from complaints analysis.

The KPH 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.

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

Recruitment and selection policies and procedures adhered to legislation and best practice guidance for the recruitment of staff. These arrangements ensure that all required recruitment documentation has been sought and retained for inspection.

A review of a sample of personnel files of staff recruited confirmed that new staff have been recruited as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005. There was evidence of job descriptions for specific staff roles. It was confirmed that professional registrations are checked as part of recruitment by the human resource department and annually thereafter by the staff member's line manager.

The KHG training academy provides an ongoing training programme. All staff are facilitated and encouraged to take part in ongoing training to update their knowledge and skills, relevant to their role. The training academy provides Ms Macartney with a monthly update of completed staff training.

An electronic system was in place to monitor all aspects of ongoing professional development and a record was retained of all training and professional development activities. A review of the electronic system confirmed a high level of compliance. Staff had either completed or were in the process of completing training as outlined in the RQIA training guidance and legislation.

Induction programmes relevant to roles and responsibilities are required to be completed when new staff join the team. Ms Macartney confirmed that the staff induction booklet is currently undergoing revision to define the onboarding requirements for different staff groups.

Discussion with Ms Macartney, in conjunction with a review of documentation, confirmed that robust arrangements were in place to check the registration status for all clinical staff on appointment and twice yearly on an ongoing basis. The arrangement for monitoring the professional indemnity of all staff was also in place.

Cardiac surgery

It was confirmed that KPH has appointed a clinical nurse educator who is an experienced cardiac ICU nurse. The clinical nurse educator is responsible for the development and implementation of an education programme for all disciplines of staff involved in the post – operative care of cardiac patients.

It was confirmed that validated competency and assessment tools such as ICU Critical Care Network Northern Ireland (CCaNNI) tools and cardiac tools have been used to devise competency assessments for staff in ICU.

A number of staff are undertaking a University College London ICU course, which is hoped to form part of the formal professional development of ICU nurses in the future. It was confirmed that all KPH ICU nurses have undertaken a validated cardiology course.

A review of records evidenced that ICU staff receive induction training and orientation to the ICU facility. ICU staff have undertaken cardiac advanced life support (CALS), intermediate life support (ILS) and advanced life support (ALS) training and completed all mandatory training.

It was confirmed that the training and competency for nurses at ward level in relation to caring for post-operative cardiac surgery patients has been redevised and expanded. The clinical nurse educator has devised a new learning plan and a self-directed training log for cardiac surgery. The clinical nurse educator also provides direct learning support/mentorship and training to ward level nurses for post-operative cardiac surgery patients on an individual rotational basis. It had been completed by a number of nurses to ensure there are appropriately trained and competent nurses to care for post-operative cardiac surgery patients during their recovery at ward level.

Consultant medical staff have declared competency in providing specialised cardiac surgery through a detailed competency framework which forms part of a review of qualifications and experience before they are granted practising privileges by the chair of the MAC.

It was confirmed that a series of workshops for RMOs have been facilitated by the lead cardiac surgeon and clinical nurse educator on the post-operative care of cardiac patients at ward level. Most RMOs have attended, with two further workshops planned for October and November 2025 where new members of the RMO team can attend. It was good to note that nurses also availed of the workshops. In addition, advanced nursing workshops were held in June and July 2025 with 13 nurses in attendance.

The cardiac theatre training and competencies for anaesthetic and scrub nurse roles was reviewed. It was confirmed that long term bank theatre nurses with experience in cardiac surgery who are also working in HSC cardiac theatres continue to assist in the cardiac surgery in KPH. The development the KPH theatre nurse's role for cardiac surgery has been ongoing since the last RQIA inspection. A cardiac theatre nurse competency booklet has been completed for a number of theatre nursing staff to undertake the scrub nurse role in cardiac surgery. In additional, a competency framework has been developed for the anaesthetics nurse's role in cardiac surgery and has been completed by a number of KPH nurses. It is good to note robust development opportunities for KPH theatre nurses.

It was determined that appropriate staffing levels are in place to meet the needs of patients and the staff were suitably trained to carry out their duties.

5.2.3 Are there safe practices in place for the day surgery and inpatient services?

The arrangements for the provision of day surgery and inpatient services as outlined in the statement of purpose and categories of care were reviewed.

It was confirmed that patients are admitted by way of the health and social care (HSC) waiting list initiative or as planned surgery under the care of a consultant surgeon.

It was confirmed that patients are reviewed by a consultant, anaesthetist and a pre-operative nurse in the outpatient department prior to admission. Patients are provided with information regarding their treatment which includes the risks and benefits associated with their planned programme of care. It was also confirmed that interpreting services are arranged by the booking office when required.

The role of the hospital liaison nurse (HLN) was reviewed and it was confirmed that patients are contacted by the HLN prior to admission. It was confirmed that the HLN gathers and collates information regarding the patient's admission, including the patient's medical history and management of activities of daily living. This information is then communicated to the inpatient unit staff. The HLN also contacts the patient prior to admission to confirm discharge arrangements and will also contact the community team if additional arrangements are required.

The inpatient unit is divided into five wards and a day procedure unit, which is currently not in use.

The inspectors visited the inpatient wards, observed care, spoke to staff and reviewed a number of patient records. The facilities and premises were found to be appropriate for the services that were delivered.

It was evidenced that care is delivered in a co-ordinated way between the inpatient wards and theatres, creating an efficient patient flow though the service.

Discussion with staff in the inpatient unit confirmed that on admission to the inpatient unit, patients are reviewed by the inpatient nursing and medical staff who complete the patient pathway, including pre-operative checklists and risk assessments prior to the patient being transferred to the theatre department.

Observations and discussion with staff confirmed that arrangements were in place to refer patients to other members of the multidisciplinary team (MDT) based on the patient's assessed need.

Staff were observed to be compassionate, and positive interactions were observed between staff and patients as staff entered and exited patient's rooms. Staff introduced themselves to patients and requested permission to enter the patient's room and then went on to explain why they were there in a kind and caring manner. During observation of care practices and discussion with staff it was evident that patients' needs were being attended to in a timely manner.

Discussion with staff confirmed that a wide choice of nutritious meals were offered that included specific meals for patients requiring specialised diets, and meal times that were flexible and individually tailored according to the patient's wishes and needs. Nursing staff confirmed that they would contact the kitchen staff regarding nutrition and the specialised dietary descriptors as outlined in the International Dysphagia Diet Standardisation Initiative (IDDSI), if required.

The inspection team observed evidence of good pain management and control. Discussion with staff confirmed that pain was assessed regularly and prior to routine practices being performed for example: wound dressing and movement. It was also confirmed that the pain management of each patient was a priority and that medical staff were readily available if further pain relief prescriptions were required. Discussion with staff confirmed that pain medication is administered as prescribed in the medicine Kardex and arrangements are in place for pain relief to be prescribed out of hours, if required. Staff confirmed they are adequately trained in medicines management and are competent in the administration of controlled drugs.

The management of wound and pressure area care was discussed and it was confirmed that various wound and pressure area care assessment tools were in place.

A review of a sample of patient care records noted that these assessment tools were completed consistently. Discussion with staff confirmed that there was a patient-centred approach to pressure area care and advised of the various aims of wound care for patients with wounds and pressure sores.

Staff had a sound knowledge of wound management and the use of aseptic non-touch technique (ANTT). It was also confirmed that there was an adequate supply of pressure relieving equipment.

It was confirmed that there is a planned programme for discharge in place and that patients are provided with a discharge letter which is shared with the patient's GP, a supply of medications and written information with advice on managing their condition following their procedure. It was also confirmed that patients are provided with details regarding any outpatient review appointments prior to discharge. It was evidenced that information was available for patients to contact the service if they had concerns following discharge.

A sample of patient care records were reviewed and it was confirmed that a comprehensive assessment of their health care needs is completed using evidence based assessment tools. It was noted that patient care records included a contemporaneous note of each patient's medical history and treatment provided. However, it was identified that some professional registration details of staff were incomplete. This matter was discussed with Ms Macartney who provided assurances that this matter would be reviewed.

Nursing staff demonstrated a good knowledge of assessment and ongoing review of pain management. Pain management records were maintained to a satisfactory standard.

Staff described excellent links with the MDT to optimally manage this area of care for patients.

During a tour of some areas of the inpatient units, it was observed that clinical areas were clean, tidy and uncluttered. There were hand hygiene facilities available throughout the unit. All areas of the inpatient units observed were equipped to meet the needs of patients.

It was determined that safe practices were in place for the inpatient and day procedure services.

5.2.4 How does the service ensure that cardiac and other surgical services are safe?

Cardiac Surgical Pathway

The arrangements for the provision of cardiac surgery services were reviewed. Staffing arrangements for the provision of the cardiac surgery service in KPH were examined across all staff disciplines. It was confirmed that a multidisciplinary team comprising of:

- an ICU lead doctor- consultant anaesthetist
- ICU consultant anaesthetists
- cardiac surgeons
- PACU manager
- a team of ICU trained nurses
- clinical equipment technicians
- theatre staff experienced in cardiac surgery
- perfusionists
- ward nursing staff
- resident medical officer (ward level)
- radiographers on call
- physiotherapist with respiratory experience
- allied health professionals (as required)
- clinical nurse educator (providing an education programme to staff)
- IPC lead nurse (consultation)
- clinical microbiologist
- senior pharmacist and supporting pharmacists.

The cardiac surgery patient journey was examined, through discussion with key medical and nursing staff, review of the facilities, scrutiny of relevant policies/ procedures and care pathway documentation.

It was confirmed that there will be a clear selection criterion in place for KPH cardiac surgery patients. With the absolute exclusion criteria of patients under 18 years of age; weight must not be greater than 155kg; and patient must not be pregnant. The selection criteria have a list of clinical conditions as contraindications for selection which are set out in a KPH Intensive Care Unit Criteria for Case Selection policy.

Referrals

Referrals for cardiac surgery will be through a HSC cardiac surgeon and the patient will have an already identified need for a specific cardiac surgical procedure. They may be self-funding patients or patients with health insurance cover.

Pre-admission

A detailed pre-admission assessment of the patient will be carried out jointly by a cardiac surgeon and a consultant cardiac anaesthetist. The case will then be presented at the weekly ICU governance meeting for consideration by the MDT. Taking into account the KPH selection criteria and the patient's fitness for surgery, a decision will be made if the patient is suitable for cardiac surgery in KPH.

Pre –operative assessment

If deemed suitable, they will have an extensive pre-operative assessment and work up to ensure they are suitable for the KPH enhanced cardiac surgery -cardiothoracic surgery care pathway protocol.

At the outpatient consultation, the patient will receive an information booklet which includes information to help decision making and consent while waiting for cardiac surgery.

Scheduling Theatre/ Pre-operative care following admission

The lead cardiac surgeon in KPH confirms the schedule and the theatre list with the involvement of the consultant cardiac surgeon, consultant cardiac anaesthetist, theatre manager and PACU manager.

The following is the care pathway for the patient on admission: -

- the patient will be admitted either the night before or on the day of surgery to ensure that all markers are stable, and the patient is fit for theatre. A pre-operative assessment will be completed. The cardiac surgery care pathway, which is a MDT care pathway covering the patients journey from admission to discharge, will be commenced.
- the patient will be seen by the consultant anaesthetist and anaesthetic assessment is completed. It was noted there was a section in the cardiac surgery care pathway for the consultant anaesthetist to complete. However, a separate anaesthetic record was completed and the anaesthetic record within the cardiac surgery pathway documentation had not been completed. It was advised to link the anaesthetic record with the main cardiac surgery care pathway, and in due course amend the record to reflect current arrangements for the recording of anaesthetic care.
- the patient will be seen by the surgeon who will confirm there is no clinical change in the patient, consent obtained and any further questions answered.
- the anaesthetist will advise regarding night sedation and any routine medications to be omitted.
- the cardiac surgeon will complete the thrombus/bleeding risk and will confirm any anti-coagulation therapy required with the RMO.

Intra –operative care

The patient is accompanied to theatre by a ward nurse. If sedative pre-medication has been prescribed, this is administered in the bed. Theatre 4 has been identified for cardiac surgery as it is adjacent to the ICU facility. An anaesthetic nurse meets the patient at theatre door and carries out a detailed checklist.

The patient is taken into theatre where pre-operative health and safety equipment checks are completed and recorded.

A detailed cardiac theatre safety checklist is carried out, this includes the World Health Organisation surgical safety checklist and surgical pause. This is recorded in the theatre section of cardiac surgery care pathway documentation. It was advised to include the completion of the cardiac surgical safety checklist in the audit programme. The operation is carried out and the patient is monitored throughout.

The intra-operative documentation is completed including a comprehensive anaesthetic record; details of skin prep; pacing wires used; chest wound drainage systems inserted; specimens sent to the laboratory; cardiac theatres check form (swabs, disposables, sutures/needles); cardiac theatre sterilisation details; cardiac theatre implant details; central venous catheter (CVC) checklist; fluid balance; critical care unit (CCU) medicine Kardex and a blood transfusion record, if required.

Two perfusionists are on site, one in the theatre with the patient and one in the theatre suite with a back-up bypass machine in a state of readiness should it be required.

The surgical register is completed. The operation notes are completed by the cardiac surgeon.

ICU care

Following the successful conclusion of surgery, the ventilated patient is admitted to the ICU where the patient commences the ICU component of the cardiac surgery care pathway. A full handover is given from theatre team to the ICU team. The ventilator settings and position is checked as per clinical technician set up. Staff ensure that a peripheral line observation is in place and that all lines are labelled. Staff ensure all lines; catheter; pacing wires; drains; delirium score is documented in the comprehensive ICU observation chart. The patient is cared for on a 1:1 ratio by a trained ICU nurse. Nurse handovers take place throughout the patients stay in ICU/High dependency Unit (HDU) and ward level at 7.45am and 7.45pm daily at the change of shift or when handing over for staff rest breaks.

While the patient is in ICU the medical cover will include the following: -

- the operating team are on the premises for at least one hour after the last case is admitted to ICU. They confirm with person in charge in ICU before they leave the premises.
- there is a live-in consultant anaesthetist 24 hours a day until the patient returns to the ward.
- there is an on call cardiac surgeon and surgical team.
- a consultant surgeon reviews the patient daily.
- a consultant anaesthetist carries out twice daily ward rounds morning and evening whilst patient is in ICU/HDU.
- a daily MDT ward round is carried out.

The usual recovery involves that on day one post–operatively, the patient is extubated and the HDU section of the cardiac surgery care pathway is commenced. Patients have an echocardiogram carried out prior to transfer from ICU to ward as an extra precaution.

Transfer from ICU to ward level

On day two, the transfer to ward checklist is commenced. If a patient meets the KPH discharge criteria from ICU to the ward the patient is transferred to ward level.

The decision to transfer to the ward is made by the consultant anaesthetist and the cardiac surgeon. Patients are only transferred to the ward between the hours of 8:00am and 6:00pm.

An appropriately trained and skilled ward nurse joins the ICU team in the ICU department the morning of the planned transfer to the ward to facilitate continuity of care and effective transfer for the patient from ICU to ward level.

The ward nurse transfers with the patient to ward level and continues to care for the patient. The patient is located in a single bedroom which is spacious enough to accommodate a range of clinical equipment. The patients' rooms are located on the same floor as ICU and the cardiac theatre 4. The ward level section of the cardiac surgery care pathway is commenced. The patient remains on monitoring for 48 hours post discharge to the ward via telemetry link to the nursing station. There is an MDT approach to care with physiotherapy daily input if required.

It was confirmed the medical cover at ward level is a RMO providing 24 hour live-in cover with the remote support of the consultant cardiac surgeon and consultant anaesthetist. The lead cardiac surgeon is on site during the day whilst the cardiac post-operative patients are recovering at ward level. It was confirmed that the consultant surgeon and consultant anaesthetist are contactable by phone and available to attend within 30 minutes following ICU/HDU discharge.

The consultant surgeon conducts a daily ward round with the nursing team looking after the patient on the ward. During this ward round the management decisions on the patient's continuity of care are taken and documented in the cardiac surgery care pathway accordingly.

A consultant-to-consultant handover takes place should there be a change in the consultant in charge of the patient.

Discharge from KPH

There are clear discharge procedures in place and the patient is deemed fit for discharge by the consultant cardiac surgeon. The discharge section of the cardiac surgery care pathway is completed by the nursing staff and the RMO. This includes arrangements for providing the patient with written discharge information and education booklets; referral to the Health Education and Rehabilitation Therapy (HEART) team; GP letter; district nurse letter; drug information list; medication; warfarin booklet; patients own medication; outpatients review planned and details of how to contact the ward for advice or if concerned.

If required, a referral may be appropriate to the psychotherapy and counselling service. A decision to make this referral will be made by the consultant cardiac surgeon in conjunction with the members of the MDT responsible for the patients' post-operative care.

It was confirmed that following discharge patients receive at least two follow up calls from suitably trained and deemed competent nursing staff who will conduct the calls in line with an agreed script which will be fully documented. Any concerns will be escalated to the RMO in the first instance who may then contact the consultant cardiac surgeon.

Post-operative cardiac surgery patients who do not follow the expected patient pathway.

It was confirmed that, if a patient in ICU is not deemed fit to transfer to the ward and continue to require to be cared for in ICU, adequately trained staff are in place to continue to support that patient.

This type of patient may need additional time to recover and are successfully discharged to the ward following a longer period in the HDU. The patient's ongoing plan of care will be discussed and recorded by the consultant anaesthetist and consultant cardiac surgeon.

For patients whose condition may deteriorate, the decision to return a patient to theatre or to the ICU is made by the consultant surgical team (operating consultant anaesthetist and consultant cardiac surgeon). The anaesthetist leads on these decisions whilst the patient is in the ICU/HDU and the surgeon leads once the patient has been discharged to the ward. The RMO takes part in the day to day management of the patient whilst they are on the ward under the direction of the consultant surgeon and consultant anaesthetist. There is an on call surgical team who can be in the hospital within 30 minutes.

Whilst patients selected for cardiac surgery in KPH are viewed as lower risk group, however, given the nature of the cardiac surgical programme, it is understood that a small number of patients may experience surgical complications. These patients may deteriorate quickly and on occasions require advanced therapies such as renal replacement therapy; advanced interventions relating to airway management; ventilation and cardiac assistance such as ventricular assist devices. It was noted KPH have a list of the triggers for transfer within the cardiac trigger to transfer to HSC from ICU post-operative policy.

The KPH transfer policy was in place and it outlined detailed information on post-operative patient transfer by KPH.

It was confirmed that KPH have arrangements in place for the support of Northern Ireland specialist transfer and retrieval (NISTAR) team when transferring a critically ill patient.

It was confirmed a memorandum of understanding (MOU) between the Belfast Health and Social Care Trust (BHSCT) and KPH, for the transfer of critically ill post-operative cardiac patients from KPH to a HSC ICU, has been established and is subject to review as agreed.

It was noted that a cardiac surgery audit is carried out routinely. A review of completed audit found it to be thorough and outlined clear findings. However, the action associated with the findings was not fully outlined. It was advised to further develop the audit to include an action plan, timescale for completion and identify those individuals responsible for implementation. Management were receptive to this advice and gave assurances on the matter.

There is a wide range of medical emergency equipment and medications in place in the ICU unit for cardiac surgery medical emergencies. There are robust arrangements in place for monitoring the emergency equipment and medications to ensure they are readily available and within their expiry date. All nursing staff have received cardiac advanced life support training, a number have advanced life support and all have immediate life support training. A range of emergency scenario training has also been provided.

General Surgical Services

The arrangements for the provision of other surgery services in the hospital as outlined in the statement of purpose and categories of care were reviewed. The inspection team evidenced that these services operate in accordance with best practice and national standards to ensure care delivery is safe and effective.

It was confirmed that adult and limited paediatric surgical services are provided. The scheduling of patients for surgical procedures is co-ordinated by the booking office, senior management and the theatre manager. The theatre lists take into account the individual requirements of the patient, the type of procedure to be performed, availability of equipment, staffing levels required, and any associated risks.

The patient will be 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.

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

It was confirmed that patients are observed during and after the surgery procedures by appropriately trained staff. Surgery patients are transferred to the ward area in accordance with recovery area discharge criteria by the nursing staff. It was confirmed that if there were any concerns about the patient's condition, the consultant would be immediately informed through the RMO, for ongoing management.

A surgical register for each theatre was in place and they were found to be well recorded in accordance with regulation.

It was confirmed surgical assistants are used in the hospital. The surgical assistants have practising privileges with the hospital and operate within a defined scope of practice. This is further discussed in section 5.2.1 of this report. A fully digital surgical assistant register which is accessed through SharePoint is in place. It is maintained to confirm they have been granted practising privileges with a defined scope of practice for their participation in specific surgery.

Staff confirmed they would access this register in relation to surgical assistants who were not known to them and if the individual was not on the register they would immediately escalate the matter to senior management and confirmed that the individual would not have access to theatre until confirmation of practising privileges and a defined scope of practice had been confirmed.

Kingsbridge Private Hospital North West (KPHNW) has an EN ISO 13485 certified Hospital Sterilisation and Decontamination Unit (HSDU) on site. This HSDU supplies sterile instrument packs for surgical procedures in KPH Belfast. There are robust measures in place to monitor the traceability of all surgical instruments used in the hospital.

Clinical equipment was evidenced to be clean and fit for purpose, and traceability labels were used to identify when equipment had been cleaned.

A wide range of comprehensive policies and procedures were in place to ensure that safe and effective care is provided to patients in accordance with good practice guidelines and national standards.

There were procedures for the collection, labelling, storage, preservation, transport and administration of specimens. Staff clearly described these procedures and the procedure for reporting results to the appropriate clinical staff and GPs. It was confirmed there is a contract in place with a pathology laboratory service. The pathology services are subject to internal audit.

Medical emergencies were discussed including the management of a massive blood loss emergency.

Theatre management confirmed massive blood loss drills have taken place and that an update is to be arranged in the near future. There was a separate massive blood loss tray and relevant documentation folder in place.

Theatre management confirmed that joint replacement information is provided for the National Joint Registry (NJR) with the consent of patients. The hospital similarly also participates in the Breast and Cosmetic Implant Registry (BCIR). The BCIR register was established to enable the identification of trends, complications relating to implants, and to ensure patients could be traced in the event of a product recall or other safety concern. Review of completed documentation in relation to NJR and BCIR noted they were well completed.

Patients are observed during surgery and in the recovery room, and the hospital had discharge criteria in place to confirm when patients were well enough to leave theatre recovery and to transfer to the ward area.

It was determined that safe practices were in place for delivery of cardiac and other surgery services.

5.2.5 How does the service ensure that medical emergency procedures are

There was a medical emergency policy and procedure in place and a review of this evidenced that it reflected legislation and best practice guidance.

Systems were in place to ensure that emergency medicines and equipment are immediately available and do not exceed their expiry dates.

An emergency trolley containing emergency medicines and equipment is readily accessible to each of the inpatient wards. Each trolley is checked daily by nursing staff. Emergency medicines were stored securely and oxygen was noted to be in date. There were separate adult and paediatric emergency medicines and equipment in place. It was identified that some emergency medicines were not stored in their original packaging. This was discussed with Ms Macartney and advice and guidance was provided in this regard.

Managing medical emergencies is included in the induction programme and refresher training is undertaken annually.

Relevant staff were able to describe the actions they would take in the event of a medical emergency and were familiar with the location of medical emergency medicines and equipment.

It was determined that the service had appropriate arrangements in place to manage a medical emergency.

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mr Regan, Responsible Individual; Ms Macartney Registered Manager, and the medical director, as part of the inspection process and can be found in the main body of the report.

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

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