Announced Care Inspection Report
20 June 2017

Fitzwilliam Clinic

Type of Service: Independent Hospital (IH) – Surgical Services
Address: 70-72 Lisburn Road, Belfast, BT9 6AF
Tel No: 028 9032 3888
Inspectors: Emily Campbell and Norma Munn

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 providing elective day surgery and private doctor services. There are no overnight beds provided in this service. The establishment provides services to adults only.

3.0 Service details

Organisation/Registered Provider: Fitzwilliam Partnership **Responsible Individual(s):** Mr James Small Mr Andrew Kennedy Mr Stephen Sinclair	**Registered Manager:** Ms Sheila Jordan
Person in charge at the time of inspection: Ms Sheila Jordan	**Date manager registered:** 13 January 2014
Categories of care: Independent Hospital (IH) – AH(DS) - Acute Hospital (Day Surgery) PD - Private Doctor	

4.0 Inspection summary

An announced inspection of Fitzwilliam Clinic took place on 20 June 2017 from 10.05 to 18.10.

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, Social Services and Public Safety (DHSSPS) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

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

Evidence of good practice was found in relation to appraisal, surgical services, infection prevention and control, the environment, the patient care pathway, engagement to enhance the patients' experience and maintaining good working relationships.

Issues of concern were identified in relation to recruitment and selection practice. Three staff had been recruited since the previous inspection. A review of records evidenced that these staff had commenced employment prior to receipt of enhanced AccessNI disclosure checks. The enhanced AccessNI disclosure check was still outstanding in relation to one staff member. In addition, a number of other recruitment checks as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 as amended had not been undertaken.

The Regulation and Quality Improvement Authority (RQIA) were concerned that the safeguards to protect and minimise risk to patients, during recruitment, have been compromised. Following consultation with senior management in RQIA, a serious concerns meeting was held at RQIA on 28 June 2017. Ms Sheila Jordon, registered manager, and Ms Denise Shields, practice

manager, attended this meeting on behalf of Mr James Small, Mr Andrew Kennedy and Mr Stephen Sinclair, registered persons.

At this meeting, Ms Jordan and Ms Shields provided an account of the actions taken to date. This included the systems and processes which have been implemented in order to avoid a reoccurrence and the arrangements which will be made to ensure the minimum improvements necessary to achieve compliance with the legislative requirements identified. RQIA were assured that the appropriate actions to address the identified issues were being taken. Additional information in this regard can be found in section 6.4 of this report.

Having considered the assurances provided, and to ensure sustained compliance two areas of improvement against the regulations have been made in relation to recruitment and selection practice. One area for improvement relates to ensuring that enhanced AccessNI disclosure checks have been undertaken and received prior to the commencement of employment of any new staff and that the identified staff member is supervised at all times until the enhanced AccessNI check has been received. The second area for improvement relates to ensuring that all of the information as outlined in Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005 is sought and retained, prior to the commencement of employment.

In addition to the areas of concern in relation to recruitment and selection practice, one area for improvement against the regulations in relation to advanced life support (ALS) training has been identified. Four areas for improvement against the minimum standards have been identified. These relate to induction records, monitoring the registration status of nursing staff, the development of action plans in respect of the monthly clinical record audit and the availability of minutes of staff meetings for staff reference.

No patients were available for discussion during the inspection. The two patients who submitted questionnaire responses indicated that they were very satisfied with the care and services provided.

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	3	4

Details of the Quality Improvement Plan (QIP) were discussed with Ms Sheila Jordan, registered manager, and Ms Denise Shields, practice manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action resulted from the findings of this inspection.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

4.2 Action/enforcement taken following the most recent care inspection dated 1 February 2017

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 1 February 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 returned QIP from the previous care inspection
- the previous care inspection report
- submitted complaints declaration

Questionnaires were provided to patients and staff prior to the inspection by the establishment on behalf of RQIA. Returned completed patient and staff questionnaires were also analysed prior to the inspection.

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

During the inspection the inspectors met with Ms Jordan, Ms Shields, a nurse and an administrator. A tour of the premises was also undertaken.

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

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

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

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 01 February 2017

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

6.2 Review of areas for improvement from the last care inspection dated 01 February 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 18 (3) **Stated:** Second time	The registered provider must submit evidence of the Private Doctor's current appraisal to RQIA.	**Met**
	Action taken as confirmed during the inspection: Evidence of the Private Doctor's appraisal was submitted to RQIA as requested.	
Area for improvement 2 **Ref:** Regulation 21 (3) Schedule 3 Part II (9) **Stated:** First time	The registered provider must ensure that a system is established for recording and monitoring all aspects of staff ongoing professional development, including specialist qualifications and training.	**Met**
	Action taken as confirmed during the inspection: A training overview record had been established, however, this was in respect of permanent nursing staff only. This was discussed and it was agreed that the template would be further developed to include all staff, permanent, bank, clinical and non-clinical. A revised training overview template was provided to RQIA on 5 July 2017 which included staff of all disciplines in the establishment.	
Area for improvement 3 **Ref:** Regulation 18 (1)	The registered provider must ensure there is at least one person on duty at all times with certified advanced life support (ALS) training.	**Not met**

Stated: First time	Records should be retained.	
	Action taken as confirmed during the inspection: Ms Jordan advised that permanent nursing staff had attended external training in March 2017 in this regard. However at the training, it was identified that this was not at advanced level. Ms Jordan confirmed that permanent nursing staff were booked to attend a two day ALS course commencing on 22 August 2017. This area for improvement has not been addressed and was stated for the second time.	
Area for improvement 4 **Ref:** Regulation 15 (7) **Stated:** First time	The registered provider must ensure that the infection prevention and control (IPC) advisor's report of 22 July 2016 should be brought to the attention of the Medical Advisory Committee (MAC) on Tuesday 21 February 2017. An implementation strategy to address the IPC advisor's recommendations should be devised.	
	Action taken as confirmed during the inspection: Review of the minutes of the MAC meeting, which had been deferred to 6 March 2017, evidenced that the IPC advisor's report had been discussed. An action plan had been devised to address the IPC advisor's recommendations. Since the previous inspection a further IPC assessment had been carried out by the IPC advisor on 26 May 2017. This is discussed further in section 6.4 of the report.	**Met**
Action required to ensure compliance with The Minimum Care Standards for Independent Healthcare Establishments (2014)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 20.5 **Stated:** First time	The arrangements put in place in relation to the Methylene Blue Dye are discussed with the infection prevention and control (IPC) advisor to confirm they are satisfactory.	**Met**
	Action taken as confirmed during the inspection: Ms Jordan confirmed that Methylene Blue Dye	

	is now treated as a single use item. There was no evidence of unused dye in the theatre area during the inspection.	
Area for improvement 2 **Ref**: Standard 3.1 **Stated:** First time	The adult safeguarding policy should be further developed to include the types and indicators of abuse, that safeguarding will be a topic covered at induction and documentation arrangements.	**Met**
	Action taken as confirmed during the inspection: The adult safeguarding policy had been further developed. Some minor amendments were made to the policy during the inspection. The revised policy was comprehensive and reflective of regional guidance.	
Area for improvement 3 **Ref**: Standard 9.3 **Stated:** First time	Completion of consent forms should be included in the records audit. Any issues of repeated non-compliance that are not addressed by individual surgeons should be brought to the attention of the Medical Advisory Committee (MAC).	**Met**
	Action taken as confirmed during the inspection: Review of the monthly clinical records audits evidenced that the completion of consent forms had been included. The results of audits are reported on a three monthly basis in the clinical and administration audit report which is discussed at the MAC meeting. The audits identified an improvement in the standard of clinical record keeping. Issues identified in the audits carried out by the establishment and the resultant actions taken are discussed further in section 6.5 of the report.	
Area for improvement 4 **Ref**: Standard 30.5 **Stated:** First time	The revised Venous Thromboembolism (VTE) risk assessment protocol should be ratified by the Clinic Board Group/MAC at the next MAC meeting scheduled for 21 February 2016.	**Met**
	Action taken as confirmed during the inspection: Minutes of the MAC meeting held on 6 March	

	2017 evidenced that the VTE risk assessment protocol had been be ratified by the Clinic Board Group. The VTE risk assessment protocol had been updated to reflect this.	
Area for improvement 5 **Ref**: Standard 9.3 **Stated:** First time	Venous Thromboembolism (VTE) completion should be audited and any issues identified should be brought to the attention of the MAC.	**Met**
	Action taken as confirmed during the inspection: VTE completion had been included in the clinical records audits. The audits identified an improvement in the completion of the VTE risk assessment. As discussed previously, issues identified in the audits carried out by the establishment and the resultant actions taken are discussed further in section 6.5 of the report.	
Area for improvement 6 **Ref**: Standard 5 **Stated:** Second time	The patient satisfaction survey summary report made available to patients should be further developed to include the results of all questions, the number of patients who participated in the survey and the action plan.	**Met**
	Action taken as confirmed during the inspection: Review of patient satisfaction surveys, which are collated every three months, confirmed that this matter has been addressed, with the exception of the number of patients who participated in the survey. Ms Jordan and Ms Shields explained that all patients are requested to submit questionnaire responses and as so many are received it is not feasible to collate the findings from them all. The approach taken is that the quarterly survey comprises of a selection of 10 completed questionnaires each month. Assurances were given that all responses are reviewed and any issues/suggestions identified by patients in responses are included in the survey; the remaining questionnaires are selected at random. Review of summary reports evidenced a mixture of responses by patients. Action plans had been devised to address any issues identified and used to improve the delivery of service, as appropriate.	

Area for improvement 7 **Ref**: Standard 30.2 **Stated:** First time	The minutes of the MAC meeting on 21 February 2017 should be forwarded to RQIA.	**Met**
	Action taken as confirmed during the inspection: The minutes of the MAC meeting had been submitted to RQIA as requested.	

6.3 Inspection findings

6.4 Is care safe?

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

Staffing

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

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

Induction programme templates were in place relevant to specific roles within the hospital. A sample of two evidenced that induction programmes had been completed when new staff join the establishment. One induction record had not been dated and this was brought to Ms Jordan's attention. Induction records reviewed were generic and lacked detail in relation to the specific staff roles. An area for improvement against the standards has been identified to address this.

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

There were systems in place for recording and monitoring ongoing professional development in respect of permanent nursing staff only. As discussed previously, a revised training overview template was provided to RQIA on 5 July 2017 which included permanent and bank staff of all disciplines in the establishment.

Arrangements were in place to ensure that all health and social care professionals are aware that they are accountable for their individual practice and adherence to professional codes of conduct.

Ms Jordan confirmed that a robust system was in place to review the professional indemnity status of all staff who require individual indemnity cover. Review of personnel files confirmed that medical practitioners had received the required annual appraisals and appropriate professional indemnity insurance was in place, with the exception of one medical practitioner. Ms Jordan and Ms Shields confirmed that the identified medical professional had been requested to provide evidence of their indemnity on a number of occasions. It was suggested that reference should be made to the practices and privileges agreements when requesting evidence of indemnity and if required, escalation to the MAC group. The identified medical professional's professional indemnity was made available during the inspection.

There was a process in place to review the registration details of health professionals, however, the registration details of some nursing staff was not up to date. An area for improvement against the standards has been identified to address this.

Eight personnel files of medical practitioners were reviewed and evidenced the following:

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

It was confirmed that each medical practitioner has an appointed responsible officer.

Recruitment and selection

Ms Jordan confirmed that three staff had been recruited since the previous inspection. As discussed a review of the personnel files for these staff demonstrated that not all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained. The following issues were identified:

- no criminal conviction declaration in respect of two staff members
- no physical and mental health assessment in respect of one staff member
- of the two references received in respect of one staff member, one was not from the current/most recent employer and one reference was not signed
- no evidence of an enhanced AccessNI disclosure in respect of one staff member

Review of enhanced AccessNI information identified that all three staff had commenced employment prior to receipt of an enhanced AccessNI disclosure check. In respect of two of the three staff, the checks were not received until three and four days following commencement of employment. It was confirmed that an enhanced AccessNI check had been applied for in respect of the third staff member, who commenced employment on the day prior to the inspection, however, this was still outstanding. This was discussed in detail with Ms Jordan and Ms Shields who provided assurances that in future no staff would commence work in the establishment until such time as the enhanced AccessNI check had been received. Assurances were also provided that the most recently recruited staff member (who is a non-clinical staff member) would be supervised at all times until the check was received. It was confirmed that enhanced AccessNI information was retained in keeping with AccessNI's code of practice.

Ms Jordan and Ms Shields were advised that all documents as outlined in Regulation 19 (2) Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 must be sought and retained in respect of staff recruited.

RQIA were concerned that the safeguards, to protect and minimise risk to patients during recruitment, were being compromised. A serious concerns meeting was held at RQIA on 28 June 2017 to discuss the issues identified in regards to recruitment and selection practice. Ms Jordan and Ms Shields attended the meeting on behalf of Mr Small, Mr Kennedy and Mr Sinclair, registered persons.

At the serious concerns meeting, Ms Jordan and Ms Shields provided an account of the actions taken to date. This included the systems and processes which have implemented in order to avoid a reoccurrence and the arrangements which will be made to ensure the minimum improvements necessary to achieve compliance with the legislative requirements identified. RQIA were assured that the appropriate actions to address the identified issues are being taken.

Having considered the assurances provided, and to ensure sustained compliance, two areas for improvement against the regulations have been made in relation to recruitment and selection practice. One area for improvement relates to ensuring that enhanced AccessNI disclosure checks have been undertaken and received prior to the commencement of employment and that the identified staff member is supervised at all times until the enhanced AccessNI check has been received. The second area for improvement relates to ensuring that all of the information as outlined in Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005 is sought and retained, prior to the commencement of employment.

A staff register had not been established. However, a staff register template was forwarded to RQIA on 27 June 2017 which contained all of the key elements as outlined in legislation. It was confirmed that the staff register had been populated and would be kept up to date.

There was a recruitment policy and procedure available, however, this did not fully reflect the arrangements in the establishment. A revised recruitment policy was submitted to RQIA on 6 July 2017 which was comprehensive and reflected best practice guidance. A recruitment checklist had been developed which was emailed to RQIA on 27 June 2017. The recruitment checklist detailed all of the recruitment information as outlined in the legislation to be obtained.

Surgical services

It was confirmed that the hospital has a wide range of comprehensive policies and procedures in place to ensure that safe and effective care is provided to patients which are in accordance with good practice guidelines and national standards.

Within the hospital there is a defined staff structure for surgical services which clearly outlines areas of accountability and individual roles and responsibilities.

The scheduling of patients for surgical procedures is co-ordinated by the registered manager and surgeon. The theatre lists take into account the individual requirements of the patient, the type of procedure to be performed, availability of equipment, staffing levels required, associated risks and level of sedation used.

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

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

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

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

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

On discussion Ms Jordan confirmed that the surgical checklist based on the World Health Organisation (WHO) model is used in the hospital.

The clinical records of five patients, who had previously undergone surgery in the clinic, were reviewed. The review evidenced that all surgical safety checklists were present in the records. Completion of the surgical safety checklists was included in the hospital's clinical record audit programme.

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

The hospital has discharge criteria in place from theatre recovery to the ward area for day patients.

A review of the surgical register of operations which is maintained for all surgical procedures undertaken in the hospital found that it contained all of the information required by legislation.

Safeguarding

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

Review of records demonstrated that all clinical staff in the establishment had received training in safeguarding children and adults at risk of harm, as outlined in the Minimum Care Standards for Independent Healthcare Establishments July 2014. It was confirmed by email on 6 July 2017, that arrangements had been established for non-clinical staff to also be provided with safeguarding training.

Policies and procedures were in place for the safeguarding and protection of children and adults at risk of harm. Minor amendments were made to the safeguarding adults policy during the inspection. The policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The relevant contact details for onward referral to the local Health and Social Care Trust should a safeguarding issue arise were included.

Resuscitation and management of medical emergencies

A review of medical emergency arrangements evidenced that emergency medicines were provided in keeping with the British National Formulary (BNF), and that emergency equipment as recommended by the Resuscitation Council (UK) guidelines was retained. A robust system was in place to ensure that emergency medicines and equipment do not exceed their expiry date. There was an identified individual with responsibility for checking emergency medicines and equipment.

Ms Jordan and staff spoken with confirmed that staff have undertaken basic life support training and updates and that some nursing staff had received modified advanced life support (ALS) training and updates. There is always at least one staff member with modified ALS on duty at all times. An area for improvement was identified during the previous inspection that there should be at least one person on duty at all times with certified ALS training. Ms Jordan advised that permanent nursing staff had attended external training in March 2017, however, at the training, it was identified that this was not at advanced level. Ms Jordan confirmed that permanent nursing staff were booked to attend a two day ALS course commencing on 22 August 2017. An area for improvement against the regulations has been identified for the second time in this regard.

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

Discussion with Ms Jordan and staff demonstrated that they have a good understanding of the actions to be taken in the event of a medical emergency and the location of medical emergency medicines and equipment.

The policy for the management of medical emergencies reflected best practice guidance. Protocols were available for staff reference outlining the local procedure for dealing with the various medical emergencies. Ms Jordan was advised that the policy should be dated and a review date identified.

Infection prevention control and decontamination procedures

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

The hospital contracts an independent IPC nurse to undertake audits and provide advice and guidance. A microbiologist is also similarly available to provide advice and guidance and to undertake visits if required. The independent IPC nurse had undertaken an audit on 26 May 2017. It was noted that an action plan to address the recommendations of the independent IPC audit had been generated and the hospital continue to progress the issues identified. Significant improvement has been made in addressing IPC issues.

A tour of the premises was undertaken which were observed to be clean, tidy and well maintained. There was a range of information for patients and staff regarding hand washing techniques.

Arrangements were in place to ensure the decontamination of equipment and reusable medical devices is in line with manufacturer's instructions and current best practice. Ms Jordan

confirmed single use equipment is used where possible. As discussed previously, Methylene Blue Dye is now treated as a single use item.

Ms Jordan confirmed that staff have been provided with IPC training commensurate with their role. Discussion with staff confirmed they had a good knowledge and understanding of IPC measures.

The clinic monitors and records surgical site infections in patients returning to the clinic for follow up and these are recorded in the quarterly clinical and administration audit report for discussion at the MAC meeting.

A range of IPC policies and procedures were in place; these were not reviewed during the inspection.

Environment

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

Cleaning schedules were in place for all areas and a colour coded cleaning system was also in place.

Ms Jordan confirmed that arrangements are in place for maintaining the environment.

Staff confirmed that fire safety awareness training had been provided and demonstrated the action to be taken in the event of a fire.

Patient and staff views

Two patients submitted questionnaire responses to RQIA. Both indicated that they felt safe and protected from harm and indicated they were very satisfied with this aspect of care. No comments were included in submitted questionnaire responses.

Six staff submitted questionnaire responses. All indicated that they felt that patients are safe and protected from harm and that they were very satisfied with this aspect of care. Staff spoken with during the inspection concurred with this. The following comment was provided in a submitted questionnaire response:

- "Nurse training is kept up to date therefore giving patients best care possible."

Areas of good practice

There were examples of good practice found in relation to appraisal, surgical services, infection prevention and control and the environment.

Areas for improvement

Induction record templates should be further developed to provide more detail and be role specific. Induction records should be signed and dated by the staff member and the mentor.

Arrangements should be made to monitor the registration status of all nursing staff at the time of renewal on an annual basis.

Enhanced AccessNI disclosure checks must be undertaken and received prior to the commencement of employment for all new staff recruited, including self-employed staff. The identified staff member must be supervised at all times until the enhanced AccessNI check has been received.

All of the information as outlined in Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005 must be sought and retained, prior to commencement of employment.

There should be at least one person on duty at all times with certified ALS.

	Regulations	Standards
Total number of areas for improvement	3	2

6.5 Is care effective?

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

Care pathway

Ms Jordan confirmed that patients are provided with comprehensive information prior to their admission which outlines any pre-operative requirements and the arrangements for their stay in the hospital.

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

- patient personal information
- holistic assessments
- pre-operative checks
- signed consent forms
- surgical safety checklist
- VTE risk assessment
- operation notes
- anaesthetic notes
- medical notes
- nursing notes
- intra-operative care plans
- recovery care plans
- post-operative care plans
- a statement of the patient's condition prior to discharge
- discharge plan

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

Discharge planning

The hospital has a discharge policy and procedure in place.

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

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

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

Records

Patient care records are audited on a monthly basis and results are included in the quarterly clinical and administration audit report for discussion at the MAC meeting. Review of clinical record audits evidenced an improvement in the completion of patient care records.

Deficiencies identified included the full completion of consent forms, VTE risk assessments and surgical safety checklists. Ms Jordan confirmed that she had discussed deficiencies with the nursing staff or individual consultants involved. However, although a general action plan was included in the clinical and administration audit report there was no action plan devised for the monthly audits and no record retained of the discussions with nursing staff or consultants. An area for improvement has been identified against the standards that an action plan is generated for each monthly clinical record audit and actions taken to improve compliance recorded, including the details of staff who were spoken with. This should help identify any areas of continued non-compliance by individual personnel as part of the quality improvement process.

Information was available for patients on how to access their health records, under the Data Protection Act 1998.

The establishment is registered with the Information Commissioner's Office (ICO), valid to 22 February 2018.

Discussion with staff confirmed they had a good knowledge of effective records management. Ms Jordan confirmed that the hospital has a range of policies and procedures in place for the management of records which includes the arrangements for the creation, use, retention, storage, transfer, disposal of and access to records.

Ms Jordan also confirmed that the hospital has a policy and procedure in place for clinical record keeping in relation to patient treatment and care which complies with (GMC) guidance and Good Medical Practice and other professional bodies' guidance.

The management of records within the establishment was found to be in line with legislation and best practice.

Patient and staff views

Both patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them and indicated they were very satisfied with this aspect of care. No comments were included in submitted questionnaire responses.

All submitted staff questionnaire responses indicated that they felt that patients get the right care, at the right time and with the best outcome for them and indicated they were very satisfied with this aspect of care. Staff spoken with during the inspection concurred with this. The following comment was provided in a submitted questionnaire response:

- "Record keeping is meticulous and all patients' notes are maintained within professional code of practice."

Areas of good practice

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

Areas for improvement

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

	Regulations	Standards
Total number of 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 with Ms Jordan and staff regarding the consultation and treatment process confirmed that patient's modesty and dignity is respected at all times. Private consultation rooms were observed to be provided for patients to meet with the medical practitioners containing modesty screens. Private individual changing rooms are available close to the theatre. The establishment has a recovery area that can accommodate up to two patients which are in close proximity with each other and divided by curtains. The design and size presents challenges to nursing and medical staff in ensuring the privacy and confidential of patients. Ms Jordan confirmed that, where possible, only one patient will be cared for in the recovery area at a time.

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.

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

Discussion with Ms Jordan and staff confirmed that patients are treated and cared for in accordance with legislative requirements for equality and rights. Patient care records were observed to be stored securely within locked filing cabinets within a secure room. Electronic records are accessed using individual user names and passwords.

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

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

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

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

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

Breaking bad news

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

The hospital retains a copy of these guidelines and this is accessible to staff.

Ms Jordan confirmed that bad news is delivered to patients and/or their representatives by senior clinicians who have experience in communication skills and act in accordance with the hospital's policy and procedure.

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

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

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

Patient consultation

The establishment obtains the views of patients and/or their representatives on a formal and informal basis as an integral part of the service they deliver. All questionnaire responses are reviewed and quarterly audits are carried out of a selection of 10 completed questionnaires each month. Assurances were given that all responses are reviewed and any issues/suggestions identified by patients in responses are included in the survey; the remaining questionnaires are selected at random. Review of summary reports evidenced a mixture of responses by patients. Action plans had been devised to address any issues identified and used to improve the delivery of service, as appropriate. The results of the quarterly audit is included in the quarterly clinical and administration audit report for discussion at the MAC meeting.

Comments provided by patients in the most recent quarterly clinical and administration audit reports included the following:

- "Positive experience – 100%."
- "Nurses are fabulous. V competent team."
- "100% excellent care. Made to feel so comfortable."
- "Fantastic clinic… Would recommend to anyone."
- "A big thank you to *xxx* and all his staff."

Patient and staff views

Both patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care and indicated they were very satisfied with this aspect of care. No comments were included in submitted questionnaire responses.

All submitted staff questionnaire responses indicated that they felt that patients are treated with dignity and respect and are involved in decision making affecting their care. All staff indicated they were very satisfied with this aspect of care. Staff spoken with during the inspection concurred with this. The following comment was provided in a submitted questionnaire response:

- "All patient information is kept confidential."

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

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

Management and governance arrangements

There was a clear organisational structure within the hospital and staff were able to describe their roles and responsibilities and were aware of who to speak to if they had a concern. Since the previous inspection Ms Shields has been recruited as the practice manager. Ms Shields demonstrated she had a clear vision regarding review of the current arrangements to further enhance quality assurance processes and the running of the hospital.

Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. There was a nominated individual with overall responsibility for the day to day management of the hospital.

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

Staff meetings are held on a monthly basis and minutes are retained. However, it was confirmed that the minutes were not available for staff reference who were unable to attend the meeting. An area for improvement against the standards has been identified in this regard. There is an informal daily meeting with staff each morning to discuss the arrangements for the day.

Policies and procedures were available for staff reference which are reviewed on at least a three yearly basis. Ms Jordan and Ms Shields were advised to ensure that policies are dated and a review date identified. Staff spoken with were aware of the policies and how to access them.

Arrangements were in place to review risk assessments.

A copy of the complaints procedure was available in the hospital. Staff demonstrated a good awareness of complaints management. A complaints questionnaire was forwarded by RQIA to the hospital for completion and the returned questionnaire confirmed that some complaints had been received. Review of complaints investigation records evidenced that complaints have been managed in accordance with best practice.

The establishment has arrangements 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. This included:

- clinical records
- accidents and incidents
- complaints
- infection prevention and control
- post surgery infections
- emergency/re-operations
- patient satisfaction.

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

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

Eight medical practitioner's personnel files were reviewed and confirmed that there was a written agreement between each medical practitioner and the establishment setting out the terms and conditions of practising privileges which has been signed by both parties. There are systems in place to review practising privileges agreements every two years. However, whilst applications for renewal of practicing privileges by medical practitioners were observed, there was no evidence that renewal of these had been granted as outlined in the policy. A template authorising the renewal of practicing privileges was devised following the inspection to address this matter, which was submitted to RQIA on 21 June 2017.

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

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

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

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

Patient and staff views

Both patients who submitted questionnaire responses indicated that they felt that the service is well led and indicated they were very satisfied with this aspect of the service. No comments were included in submitted questionnaire responses.

All submitted staff questionnaire responses indicated that they felt that the service is well led. Four staff indicated they were very satisfied with this aspect of the service and two indicated they were satisfied. Staff spoken with during the inspection concurred with this. The following comment was provided in a submitted questionnaire response:

- "Line manager is always available to discuss any concerns. Patient concerns/complaints are dealt with promptly. Policies and procedures are kept up to date and readily available."

Areas of good practice

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

Areas for improvement

Minutes of staff meetings should be made available to staff who are unable to attend the meeting.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Sheila Jordan, registered manager and Ms Denise Shields, practice manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the independent hospital. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health, Social Services and Public Safety (DHSSPS) 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 to Independent.Healthcare@rqia.org.uk for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 19 (2) **Stated:** First time **To be completed by:** 28 June 2017	The registered person shall ensure that enhanced AccessNI disclosure checks are undertaken and received prior to the commencement of employment for all new staff recruited, including self-employed staff. The identified staff member must be supervised at all times until the enhanced AccessNI check has been received. Ref: 6.4
	Response by registered person detailing the actions taken: The registered person can confirm that the accessni enhanced will be undertaken and received prior to the commencement of employed of new staff, including self-employed staff. The identified staff member that had not received the enhanced Accessni check prior to employment no longer works at Fitzwilliam Clinic.
Area for improvement 2 **Ref:** Regulation 19 (2) Schedule 2 **Stated:** First time **To be completed by:** 28 June 2017	The registered person shall ensure that all of the information as outlined in Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005 is sought and retained, prior to the commencement of employment. Ref: 6.4
	Response by registered person detailing the actions taken: The registered person can confirm that all information in Schedule 2 of the independent Healthcare Regulations(NI) 2005 is sought and retained, priorto commencement of employment.
Area for improvement 3 **Ref:** Regulation 18 (1) **Stated:** Second time **To be completed by:** 20 September 2017	The registered person shall ensure there is at least one person on duty at all times with certified advanced life support (ALS) training. Records should be retained. Ref: 6.4
	Response by registered person detailing the actions taken: The registered person can confirm that there will be at least one person on duty at all times with ALS training. This will be completed by 20 September 2017 and the records will be retained.
Action required to ensure compliance with The Minimum Care Standards for Independent Healthcare Establishments (2014)	

Area for improvement 1 **Ref**: Standard 10.11 **Stated:** First time **To be completed by:** 20 September 2017	The registered person shall further develop induction record templates to provide more detail and be role specific. Induction records should be signed and dated by the staff member and the mentor. Ref: 6.4
	Response by registered person detailing the actions taken: The Registered person is presently updating and developing the induction, this will be completed by 20 September 2017
Area for improvement 2 **Ref**: Standard 10.1 **Stated:** First time **To be completed by:** 20 July 2017	The registered person shall make arrangements to monitor the registration status of all nursing staff, at the time of renewal, on an annual basis. Ref: 6.4
	Response by registered person detailing the actions taken: The registered person can confirm we now have a process that will monitor nurse registration, at the time of renewal, on an annual basis.
Area for improvement 3 **Ref**: Standard 9.4 **Stated:** First time **To be completed by:** 20 July 2017	The registered person shall generate an action plan for each monthly clinical record audit and record actions taken to improve compliance, including the names of staff who were spoken with. Ref: 6.5
	Response by registered person detailing the actions taken: An action plan has been devised for the monthly clinical audits. This will show the action required when and by whom.
Area for improvement 4 **Ref**: Standard 12.7 **Stated:** First time **To be completed by:** 20 July 2017	The registered person shall ensure that minutes of staff meetings are made available to staff who are unable to attend the meeting. Ref: 6.7
	Response by registered person detailing the actions taken: The minutes of the staff meetings will be available for all staff who are unable to attend a meeting. This will include their signature that minutes have been read.

Please ensure this document is completed in full and returned to Independent.Healthcare@rqia.org.uk from the authorised email address

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal.

If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

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