Announced Care Inspection Report
7 February 2017

Cathedral Eye Clinic

Type of service: Independent Hospital (IH) - Refractive Eye lasers
Address: 89 - 91 Academy Street, Belfast, BT1 2LS
Tel no: 0289032 2020
Inspector: Elizabeth Colgan

1.0 Summary

An Announced inspection of Cathedral Eye Clinic took place on 7 February 2017 from 10.00 to 15.30.

The inspection sought to determine if the refractive laser eye surgery service was delivering safe, effective and compassionate care and if the service was well led. The inspection was facilitated by Mr Gary McArdle Acting Registered Manager. Dr Ian Gillan, RQIA's medical physics advisor carried out a visit to Cathedral Eye Clinic on 7 February 2017. Dr Gillan's findings and report is appended to this report.

Is care safe?

Observations made, review of documentation and discussion with Mr Gary McArdle acting registered manager and staff demonstrated that further development is needed to ensure that care provided to patients is safe and avoids and prevents harm. Areas reviewed included staffing, recruitment and selection, safeguarding, laser safety, management of medical emergencies, infection prevention control and decontamination and the general environment. A requirement has been made in relation to selection and recruitment. Three recommendations were made in relation to, safeguarding, laser safety and infection prevention and control which all relate to quality assurance and good governance. Addressing the requirement and recommendations made will further enhance the quality and governance arrangements in place.

Is care effective?

Observations made, review of documentation and discussion with Mr McArdle, and staff demonstrated that further development is needed to ensure that care provided in the establishment is effective. Areas reviewed included care pathway and communication. One recommendation has been made in relation completion of consent forms.

Is care compassionate?

Observations made, review of documentation and discussion with Mr McArdle and staff demonstrated that arrangements are in place to promote patients' dignity, respect and involvement in decision making. No requirements or recommendations have been made.

Is the service well led?

Information gathered during the inspection identified that further development is needed to ensure that effective leadership and governance arrangements are in place and create a culture focused on the needs of patients in order to deliver safe, effective and compassionate care. Areas reviewed included organisational and staff working arrangements, the arrangements for policy and risk assessment reviews, the arrangements for dealing with complaints, incidents and alerts, arrangements for practising privileges, insurance arrangements and the registered person's understanding of their role and responsibility in accordance with legislation. A number of quality assurance processes were in place. However as discussed previously issues were identified in relation to recruitment and selection, safeguarding, laser safety and infection prevention and control under the 'is care safe' domain and completion of consent forms under 'is care effective 'domain which all relate to quality assurance and good governance. Addressing the requirement and

recommendations made will further enhance the quality and governance arrangements in place.

This inspection was underpinned by 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 (DHSPPS) Minimum Care Standards for Independent Healthcare Establishments (July 2014).

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr Gary McArdle Acting Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 7 February 2017.

2.0 Service details

Registered organisation/registered person: Cathedral Eye Clinic Ltd (registration pending) Dr Jonathan Moore	**Registered manager:** Mr Gary McArdle acting registered manager awaiting registration
Person in charge of the establishment at the time of inspection: Mr Gary McArdle	**Date manager registered:** Awaiting registration
Categories of care: (IH) Independent Hospital PT(L) Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers and PD Private Doctor	

Laser equipment

Ophthalmic Laser

Manufacturer:	Zeiss
Model:	VISUMAX
Serial Number:	1048412
Laser Class:	Class 3b
Output Wavelength:	1043nm
Location	Third Floor Treatment Room

YAG Photo disrupter

Manufacturer:	NIDEX
Model:	YC 1600 Nd:Yag
Serial Number:	60952
Laser Class:	3B
Output wavelength:	1064nm
Location	Second Floor Treatment Room

Excimer Laser

Manufacturer:	Schwind-Amaris
Serial Number:	A779
Laser Class:	Class 4
Output wavelength:	ArF (193nm)
Location	Third Floor Treatment Room

Ophthalmic Laser

Manufacturer:	Lumenis
Model:	Selecta II SLT
Serial Number:	51883
Laser Class:	Class 3b
Output wavelength:	532nm
Location	Second Floor Treatment Room

Laser Protection Advisor (LPA) Dr Anna Bass (Lasermet)

Laser Protection Supervisor (LPS) Mr Andrew Spence

Authorised Users -

Professor Jonathan Moore – All laser equipment
Mr Andrew Spence – Schwind- Amaris Class 4 Laser
Mr Colin Willoughby - Lumenis Selecta II SLT Class 3b Laser.
Mr. Sri Kamalarajah - Nd:Yag

Medical Support Services: Professor Jonathan Moore

Type of Treatments Provided:

Refractive eye laser and other vision correction treatments:

- LASEK
- LASIK
- Cross-Linking
- Presbymax
- VISUMAX SMILE
- SLT Laser treatments(reviewed on this inspection)
- Transepi PTK
- Glaucoma

3.0 Methods/processes

Questionnaires were provided to patients and staff prior to the inspection by the establishment on behalf of the RQIA. Prior to inspection we analysed the following records: notifiable events, complaints declaration and returned completed staff and patient questionnaires.

During the inspection the inspector met with Mr Gary McArdle acting registered manager and briefly with Professor Johnathan Moore registered person, and three staff. A tour of the premises was also undertaken.

Records were examined during the inspection in relation to the following areas:

- staffing
- recruitment and selection
- safeguarding
- laser safety
- management of medical emergencies
- infection prevention and control
- care pathway
- communication
- management and governance arrangements
- practising privileges
- maintenance arrangements

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 24 February 2016

The most recent inspection of the Cathedral Eye Clinic was an announced care inspection. No requirements or recommendations were made during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 24 February 2016

As above.

4.3 Is care safe?

Staffing

Discussion with Mr Gary McArdle Acting Registered Manager confirmed that there is sufficient staff in the various roles to fulfil the needs of the establishment and patients. This includes a team of consultant ophthalmologists, optometrists, nurses and laser technicians/surgical assistants who have evidence of specialist qualifications and skills in refractive laser eye surgery.

Mr McArdle confirmed that refractive laser eye procedures are only carried out by trained medical practitioners acting as clinical authorised users and laser technicians /surgical assistants acting as non-clinical authorised users. A register of clinical and non-clinical authorised users for the laser is maintained and kept up to date. A register of all staff as outlined in Schedule 3, Part 2 (6) was not available. A staff register was completed during the inspection.

A review of completed induction programmes for two nursing staff evidenced that induction training is provided to new nursing staff on commencement of employment. However an induction programme was not available for all clinical staff this should be devised. Mr McArdle confirmed that this would be addressed.

A review of training records evidenced that all authorised users have up to date training in core of knowledge training, application training for the equipment in use. Mr McArdle confirmed that date for basic life support and fire safety has been organised. Staff should have refresher training on safeguarding when policies and procedures are updated.

All other staff employed at the establishment, but not directly involved in the use of the laser equipment, have received laser safety awareness training.

Evidence was available that confirmed that staff who have professional registration, undertake continuing professional development (CPD) in accordance with their professional body's recommendations.

Discussion with Mr McArdle and review of documentation confirmed that the systems are in place for undertaking, recording and monitoring all aspects of staff supervision, appraisal and ongoing professional development. Staff appraisals are to commence on 27 February 2017.Disscussion with staff confirmed this date.

A review of three consultant ophthalmologists' details confirmed there was evidence of the following:

- confirmation of identity
- current General Medical Council (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 GMC
- there was evidence of ongoing annual appraisal by a trained medical appraiser
- an appointed responsible officer
- arrangements for revalidation

Recruitment and selection

A review of the submitted staffing information and discussion with Mr McArdle confirmed that eleven staff have been recruited since the previous inspection. A review of the personnel files for three staff evidenced that not all staff had been recruited in line with Regulation 19(2) Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005. It was noted that the enhanced AccessNI in respect of one staff member was not received until after the commencement of employment. A requirement has been made.

Review of the identified staff personnel file demonstrated the following issues:

- None of the files reviewed contained a criminal conviction declaration
- Two references for new staff were not on file
- A health assessment had not been undertaken
- One file did not have proof of identity

Mr McArdle confirmed that a recruitment policy and procedure was in place which was comprehensive and reflected best practice guidance.

Safeguarding

Mr McArdle confirmed that policies and procedures are in place for the safeguarding and protection of adults and children at risk of harm.

Review of these indicated that they need to be updated to ensure they fully reflect the new regional policy and guidance documents issued during July 2015 and March 2016. A recommendation has been made to address this. Mr McArdle confirmed that staff would receive refresher training in safeguarding children and adults at risk of harm when the policy and procedures had been updated in keeping with the Minimum Standards for Independent Healthcare Establishments July 2014.

After the inspection the following information was forwarded to Mr McArdle by electronic mail:

- ‘Adult Safeguarding Prevention and Protection in Partnership’ (July 2015)
- ‘Adult Safeguarding Operational Procedures Adults at Risk of Harm and Adults in Need of Protection’ (September 2016)
- ‘Co-operating to Safeguard Children and Young People in Northern Ireland’ (issued March 2016)
- the relevant contact details for onward referral

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

Laser safety

A laser safety file is in place which contains all of the relevant information in relation to laser equipment.

There was written confirmation of the appointment and duties of a certified LPA .Dr Gillan's report indicates that the local rules 15 December 2015 state that they will be reviewed annually by the LPA & LPS, however there is no record that this review has taken place. The clinic should maintain records of such reviews and also copies of any correspondence with their LPA. A recommendation has been made. The service level agreement between the establishment and the LPA was reviewed and this expires in March 2017.

Refractive eye surgical procedures are carried out by trained medical practitioners in accordance with medical treatment protocols produced by Professor Jonathan Moore**.** Systems are in place to review the medical treatment protocols on an annual basis.

Up to date local rules are in place which have been developed by the LPA. The local rules contained the relevant information pertaining to the laser equipment being used.

The establishment's LPA completed a risk assessment of the premises in September 2015 and all recommendations made by the LPA have been addressed.

A list of clinical and non-clinical authorised users is maintained and authorised users have signed to state that they have read and understood the local rules and medical treatment protocols.

When the laser equipment is in use, the safety of all persons in the controlled area is the responsibility of the LPS. Arrangements are in place for another authorised user to deputise for the LPS in their absence, who is suitably skilled to fulfil the role. Discussion with Mr McArdle confirmed that systems are in place to ensure other authorised users are aware who is the LPS on duty.

The environment in which the laser equipment is used was found to be safe and controlled to protect other persons while treatment is in progress. The controlled area is clearly defined and not used for other purposes, or as access to areas, when surgery is being carried out.

The doors to the laser suite are locked when the laser equipment is in use but can be opened from the outside in the event of an emergency.

The laser equipment is operated using a key. Arrangements are in place for the safe custody of the lasers' key when not in use.

Laser safety warning signs are displayed when the laser equipment is in use and removed when not in use.

Protective eyewear is available as outlined in the local rules for laser technicians/surgical assistants if required. Dr Gillan's report indicates that the local rules for the excimer laser currently states the level of protection required for the eyewear covering the untreated eye, as the clinic currently tape gauze to this eye this matter should be discussed further with their LPA.

The establishment has a laser surgical register for all lasers which is completed every time the equipment is operated and includes:

- the name of the person treated
- the date
- the operator
- the treatment given
- the precise exposure
- any accident or adverse incident

A review of the laser surgical registers during the inspection found they were generally comprehensively completed. It was noted that there had been no exposures recorded in the Nidex Yag laser log from 27 January 2017 to 2 February 2017. A recommendation has been made.

There are arrangements in place to service and maintain the laser equipment in line with the manufacturer's guidance. Dr Gillan's report indicates that the lasers are serviced on a regular basis however the paper records maintained on file are not up to date. The clinic should ensure that the laser safety file contains up to date service records for all four lasers. A recommendation has been made.

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.

A review of training records and discussion with staff confirmed that the management of medical emergencies is included in the induction programme and training is updated on an annual basis in keeping with best practice guidance.

Discussion with 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.

Infection prevention and control and decontamination procedures

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

A range of information was available for patients and staff regarding hand washing techniques.

Arrangements were in place to ensure the decontamination of equipment and reusable medical devices in line with manufacturer's instructions and current best practice. Staff confirmed single use equipment is used where possible.

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

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

A range of IPC audits have been carried out including:

- environmental
- hand hygiene
- post treatment infection

The compliance rate was noted to be very high and an action plan was in place for areas of non-compliance.

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

A review of infection control and prevention arrangements indicated some issues for improvement:

- The record of temperatures for the fridge in the Laser Theatre were not consistently maintained, no temperatures had been recorded from the 30 January 2017

- A sharps bin for the disposal of cytotoxic waste which had been constructed on 16 December 2014, it was observed that the bin was over the fill line and the closure lid open

- The closure lid was open on all sharps bins observed

- Re-sheathed needles were observed in a sharps bin in a downstairs laser room

- The metal trolley for the oxygen cylinder was very rusty therefore could not be effectively cleaned

A recommendation has been made.

Environment

The premises were maintained to a good standard of maintenance and décor.

Detailed cleaning schedules were in place and completed records of cleaning were displayed in various areas.

A carbon dioxide (CO2) fire extinguisher was available which has been serviced within the last year.

Arrangements are in place for maintaining the environment. It was advised that all servicing records be available for inspection. An Authorising engineer report had been undertaken in November 2016. Although no written action plan had been devised for areas identified as high risk for immediate attention. Mr McArdle confirmed that action had been taken.

Mr McArdle confirmed that a fire risk assessment had been undertaken and staff confirmed fire drills had been completed and a date organised for fire safety training. Staff demonstrated that they were aware of the action to take in the event of a fire.

Patient and staff views

Twelve patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm. Comments provided included the following:

- "Excellent staff and high standards of hygiene"
- "Particularly good"
- "Excellent clean facility, very well maintained"
- "I feel well cared for"

Thirteen staff submitted questionnaire responses. All indicated that they felt that patients are safe and protected from harm. No comments were included in submitted staff questionnaire responses.

Areas for improvement

Staff must be recruited and staff files retained in line with Regulation 19(2) Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005.

Safeguarding policies and procedures should be updated and staff should receive refresher training.

Laser safety improved by ensuring the local rules are reviewed annually by the LPA & LPS, providing up to date service records for all four lasers in the laser safety file and ensuring that exposure levels for the Nidex Yag laser are completed every time the equipment is operated.

Infection control and prevention arrangements should be improved to ensure consistent monitoring of fridge temperatures, the management of sharps and repair or replacement of the oxygen trolley.

Number of requirements	1	Number of recommendations	3

4.4 Is care effective?

Care pathway

Patients have an initial consultation with a qualified optometrist who discusses their treatment options and the cost of the surgery.

During the initial consultation, patients are asked to complete a health questionnaire. There are systems in place to contact the patient's general practitioner, with their consent, for further information if necessary.

The establishment has a list of fees available for each type of surgical procedure. Fees for treatments are agreed during the initial consultation and may vary depending on the individual patient's prescription and surgery options available to them.

Mr McArdle confirmed patients meet with their surgeon, on the day of surgery, to discuss their individual treatment and any concerns they may have. Arrangements can be made for the patient to meet with the surgeon earlier if necessary.

Patients are provided with written information on the specific procedure to be provided that explains the risks, complications and expected outcomes of the treatment.

Patients are provided with clear post-operative instructions along with contact details for a senior optometrist if they experience any concerns. There are systems in place for the senior optometrist to refer patients directly to a consultant ophthalmologist if necessary.

Systems are in place to review the patient following surgery at one day, one week, one month, three months and longer if necessary.

Ten patient care records were reviewed. The establishment retains hard copy care records which are supplemented with an electronic record system. The patient care records were well documented, contemporaneous and clearly outlined the patient journey. The care records reviewed contained the following:

- patient details
- medical history
- signed consent form
- initial consultation
- pre-operative notes
- intra-operative notes
- post-operative notes
- review/follow up notes

It was noted that there are various versions of the consent forms. In the majority of files the patient had not dated the consent form and when the new consent form had been used staff had not completed their section on the day of surgery. A recommendation has been made.

Observations made evidenced that patient records are securely stored.

Systems were in place to audit the completion of clinical records and an action plan is developed to address any identified issues. The outcome of the audit is reviewed through the establishment's clinical governance structures.

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).

A review of documentation confirmed that the establishment has a range of policies and procedures in place for the management of records which includes the arrangements for the creation, use, retention, storage, transfer, disposal of and access to records.

The establishment also has a policy statement in place for clinical record keeping in relation to patient treatment and care which complies with GMC guidance and Good Medical Practice.

Communication

As discussed, there is written information for patients that provides a clear explanation of any treatment and includes effects, side-effects, risks, complications and expected outcomes. Information is jargon free, accurate, accessible, up-to-date and includes the cost of the treatment.

The establishment has a policy for advertising and marketing which is in line with legislation.

Staff confirmed that management is approachable and their views and opinions are listened to. Staff meetings are held on a monthly basis. Review of documentation demonstrated that minutes of staff meetings are retained.

Staff confirmed that there are good working relationships and there is an open and transparent culture within the establishment.

Patient and staff views

All of the 12 patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them. Comments provided included the following:

- "Very pleased to be able to speak to my consultant before my surgery"
- "Excellent communication with surgeon. Everything fully explained many times to me, had personal phone numbers to call anytime"

Thirteen 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. Staff spoken with during the inspection concurred with this. The following comment was provided:

- "Every effort is made pre/post surgery that patients are happy"

Areas for improvement

Consent forms should be fully completed.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

Dignity respect and involvement with decision making

Discussion with Mr McArdle regarding the consultation and surgery confirmed that patients' modesty and dignity is respected at all times. The initial consultation is provided in a private room with the patient and the optometrist. The surgery is provided within a designated laser suite.

Information is provided to the patient in verbal and written form at all consultations to allow the patient to make choices about their care and treatment and provide informed consent.

Patients meet with the surgeon on the planned day of surgery and are fully involved in decisions regarding their treatment. Patients' wishes are respected and acknowledged by the establishment.

Appropriate measures are in place to maintain patient confidentiality and observations made evidenced that patient care records were stored securely in locked cabinets and electronic records are password protected. Arrangements are also in place for off-site secure archiving facilities.

Patient satisfaction surveys are carried out by the establishment on an annual basis.
The results of the last report was compiled from January to October 2016 this was collated to provide a summary report which is made available to patients and other interested parties. An action plan is developed to inform and improve services provided, if appropriate.

Review of the completed report found that patients were highly satisfied with the quality of treatment, information and care received.

Patient and staff views

All of the 12 patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care. Comments provided included the following:

- "Absolutely correct"
- "Very good told if ever any questions to ring and ask, very prompt getting back to you"

Thirteen 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. Staff spoken with during the inspection concurred with this. Comments provided included the following:

- "Respect is given to every patient"
- "In reception"

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.6 Is the service well led?

Management and governance

There was a clear organisational structure within the establishment and Mr McArdle and staff, were able to describe roles and responsibilities and were aware of who to speak to if they had a concern. Staff confirmed that there were good working relationships and the management were responsive to any suggestions or concerns raised. Arrangements were in place to facilitate annual staff appraisal.

As discussed previously Mr McArdle is the acting registered manager for this clinic and has overall responsibility for the day to day management of the service. Mr McArdle confirmed by electronic mail that an application form for his registration had not yet been submitted to RQIA. Mr McArdle was advised to contact RQIA and begin the process of registration immediately. Following inspection Mr McArdle contacted the RQIA registration team and has entered the registration process.

Policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, dated and systematically reviewed on a yearly basis. Staff spoken with were aware of the policies and how to access them.

Discussion with Mr McArdle demonstrated that arrangements were in place to review risk assessments.

A copy of the complaints procedure was available in the establishment. Discussion with Mr McArdle demonstrated good awareness of complaints management. A complaints questionnaire was forwarded by RQIA to the establishment for completion. The evidence provided in the returned questionnaire indicated that complaints have been managed in accordance with best practice.

Discussion with Mr McArdle confirmed that 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 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.

Discussion with Mr McArdle confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to service users at appropriate intervals.

Mr McArdle confirmed that in the future if required an action plan would be developed and embedded into practice to address any shortfalls identified during the audit process. As discussed previously issues were identified in relation to recruitment and selection, safeguarding, laser safety and infection prevention and control under the ‘is care safe’ domain and completion of consent forms under ‘is care effective ‘ domain which all relate to quality assurance and good governance. Addressing the requirement and recommendations made will further enhance the quality and governance arrangements in place.

Arrangements are in place to support medical practitioners, with a licence to practice, to fulfil the requirements for revalidation through providing sufficient information to the responsible officer to support their revalidation, for medical practitioners who are not an employee. Mr McArdle outlined the process for granting practising privileges and confirmed medical practitioners meet with Professor Moore registered person prior to privileges being granted.

Discussion with Mr McArdle confirmed that arrangements are in place for dealing with professional alert letters and managing identified lack of competence and poor performance for all staff, including those with practising privileges. There are also mechanisms for reporting incompetence in line with guidelines issued by the Department of Health and professional regulatory bodies.

Three medical practitioner’s personnel files reviewed 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.

A policy and procedure was in place which outlined the arrangements for application, granting, maintenance, suspension and withdrawal of practising privileges.

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

The acting registered manager demonstrated a clear understanding of his role and responsibility in accordance with legislation. Information requested by RQIA has been submitted within specified timeframes. Mr McArdle 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

All of the 12 patients who submitted questionnaire responses indicated that they felt that the service is well managed. Comments provided included the following:

- "Always directed to someone who can answer my questions"
- "Well briefed prior to surgery"
- "Professor Moore and his team provide an excellent service. I have personally recommended friends and family to the clinic"
- "Everything well planned and run to schedule and to suit me"

Thirteen submitted staff questionnaire responses indicated that they felt that the service is well led. Staff spoken with during the inspection concurred with this. The following comment was provided:

- "The right team work well together"

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Gary McArdle acting registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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 laser eye surgery service. 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on 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.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The DHSSPS Minimum Care Standards for Independent Healthcare Establishments(July 2014). They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to independant.healthcare@rqia.org.uk for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements

Requirement 1 **Ref**: Regulation19(2)(d) and Schedule 2 **Stated:** First time **To be completed by: 7 March 2017**	The registered person must ensure that they have obtained all of the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 for all staff recruited since registration with RQIA and any new staff recruited. Records must be retained and available for inspection. • two written references, one of which should be from the current/most recent employer • a health assessment • criminal conviction declarations on application
	Response by registered provider detailing the actions taken: To ensure we are recruitng in line with Regulation 19(2) Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005, Cathedral Eye Clinic has embarked upon the gathering of all aspects of the RQIA Recruitment Checklist for all staff including: Start Date; Proof of ID; Birth Certificate; Passport number; Work permit (if applicable); crime conviction declaration; Date Access NI check received and serial number of check; Access NI storage; Reference 1 (most recent employer) and Reference 2; Employment history; Reasons for Leaving; Employment gaps explored; qualification evidence; GDC registration & annual checks; physical & mental health assessment; contract isue date; job description; induction and professional indemnity insurance. Gathering some of this information for staff retrospectively is currently being undertaken. Due to the fact that we have historically gathered references verbally and also relied on recruitment agencies to conduct these on our behalf, it has been challenging to gather written references for staff recruited previously. However, all staff have been Access NI approved and - going forward - we will ensure that all recruitment involves the receipt of two written references, one of which will be the current / most recent employer. All employees have been Access NI checked and going forward, any potential recruits will be Access NI checked prior to employment start.

Recommendations	
Recommendation 1 **Ref**: Standard 3 **Stated:** First time **To be completed by:** 7 April 2017	The safeguarding policy and procedure should be reviewed and updated to ensure it fully reflects the new regional policy and guidance documents issued during July 2015 and March 2016 and training provided to staff. Training records should be retained.
	Response by registered provider detailing the actions taken: The Clinic's safeguarding policy and procedure (attached) has been reviewed and updated in accordance with the latest guidance documentation - to fully reflect the new regional policy and guidance documents issued during July 2015 and March 2016. All staff have been briefed and trained in relation to the intricacies of the policies and procedures in keeping with the Minimum Standards for Independent Healthcare Establishments July 2014. Staff understand the relevant protocols and contact points, with Ms. Pat Killough assigned as our Safeguarding Manager.
Recommendation 2 **Ref**: Standard 48 **Stated:** First time **To be completed by:** 7 February 2017	The registered person should improve laser safety by ensuring the local rules are reviewed annually by the LPA & LPS, providing up to date service records for all four lasers in the laser safety file and ensuring that exposure levels for the Nidex Yag laser are completed every time the equipment is operated.
	Response by registered provider detailing the actions taken: - Anna Bass (LPA) and Andrew Spence (LPS) together ensure that the local rules are reviewed annually and dated. - All relevant service level agreements required by Cathedral Eye Clinic up-to-date. - LPA report for 2016 is now in the file. The report took place in August 2016. - Exposure levels for the Nidex Yag laser are completed every time the equipment is operated.

Recommendation 3 **Ref**: Standard 20 **Stated:** First time **To be completed by:** 7 February 2017	The registered person should improve infection control and prevention arrangements to ensure consistent monitoring of fridge temperatures, the management of sharps and repair or replacement of the oxygen trolley.
	Response by registered provider detailing the actions taken: Infection control and prevention arrangments have been further improved through: 1. The consistent monitoring of fridge temperatures for the fridge in the Laser theatre. 2. Constant monitoring and management of sharps bins to ensure fill lines are observed and lids closed at all times. 3. Ensuring zero re-sheathing of needles. 4. Metal trolley for the oxygen cylinder has been delivered and is now in use. As always, our IPC Cleaning schedule, policies and processes are being consistently monitored, implemented and updated.
Recommendation 4 **Ref**: Standard 2 **Stated:** First time **To be completed by:** 7 February 2017	The registered person should ensure that patient consent forms are fully completed
	Response by registered provider detailing the actions taken: Patient consent forms are fully completed to ensure that when it is discussed with the patient at the outset, it is dated. The following process is followed: - Detailed Consent Form provided and discussed at initial consultation by optometrist and consultant. - Patient signs and dates initial understanding of consent form contents following detailed discussion with optometrist / consultant. - Patient takes consent form home to fully read, complete, sign and date form. - Any questions are noted, then asked of the Consultant at Follow-up Appointment. - Patient brings completed form to Consultant appointment - Any questions are addressed, full form is completed & signed. - Reinforced & Summary Consent Signed by Consultant & Patient.

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

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