The Regulation and Quality Improvement Authority

Inspection Report

2 March 2022

Cathedral Eye Clinic

Type of Service: Independent Hospital (IH) – Refractive Eye Lasers
Address: 89 - 91 Academy Street, Belfast, BT1 2LS
Tel No: 028 9032 2020

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

1.0 Service information

Organisation/Registered Provider: Cathedral Eye Clinic Ltd **Responsible Individual:** Mr Jonathan Moore	**Registered Manager:** Mr Gary McArdle **Date registered:** 18 July 2017
Person in charge at the time of inspection: Mr Gary McArdle	
Categories of care: PT(L) Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers PD Private Doctor AH (DS) Acute hospitals (day surgery only)	
Brief description of how the service operates: Cathedral Eye Clinic is registered as an independent hospital (IH) with prescribed techniques or prescribed technology: establishments providing refractive eye techniques using Class 3B or Class 4 lasers PT (L); private doctor (PD) and acute hospitals (day surgery only) AH (DS) categories of care. **Laser equipment available in the service** **Floor 1 YAG Room:** Manufacturer: Quantel Medical Model: Optimis Fusion Serial Number: 62-07-0200 Output wavelength: 532 & 1064nm Laser Class: 3B Manufacturer: Quantel Medical Model: Vitra 2 Serial Number: 3434 Output wavelength: 532nm Laser Class: 4 **Floor 2 Laser Suite:** Manufacturer: Schwind-Amaris Serial Number: A779 Output wavelength: ArF (193nm) Laser Class: 4	

Manufacturer: Zeiss
Model VISUMAX
Serial Number: 1048412
Output wavelength: 1043nm
Laser Class: 3B

Floor 2 Cataract Suite:

Manufacturer: D.O.R.C
Model EVA
Serial Number: 2015000298
Output wavelength: 532nm
Laser Class: 4

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

Laser Protection Supervisor (LPS):
Ms Gillian Murdoch

Clinical Authorised Operators:
Professor Jonathan Moore - All laser equipment (with the exception of the DORC EVA)
Mr Colin Willoughby - Quantel Fusion
Mr. Sri Kamalarajah - Quantel Fusion
Mr Richard Best - Quantel Fusion and DORC EVA
Mr Wing Chan - Quantel Fusion, Quantel Vitra 2 & DORC EVA
Mr Stuart McGimpsey - Quantel Fusion, DORC EVA
Mr Andre Grixti - Quantel Fusion
Mr Murali Upendran - Quantel Fusion,DORC EVA
Mr David Armstrong- Quantel Fusion

Non-clinical Authorised Operators:
Mr Andrew Spence – All laser equipment (with the exception of the Quantel Fusion)

Medical Support Services:
Professor Jonathan Moore
Mr Richard Best and Mr Wing Chan (vitrectomy procedures only)

Type of Treatments Provided:

Refractive eye laser and other vision correction treatments:

- LASEK
- LASIK
- Cross-Linking
- Presbymax
- VISUMAX SMILE
- SLT Laser treatments
- Transepi PTK
- Glaucoma
- Vitrectomy procedures
- Capsulotomy

2.0 Inspection summary

This was an announced inspection undertaken by two care inspectors on 2 March 2022 from 10.00 am to 5.30 pm. RQIA's Medical Physics Expert accompanied the inspectors and reviewed the laser equipment and the laser safety arrangements. His findings and recommendations are appended to this report.

The purpose of the inspection was to assess progress with areas for improvement identified during and since the last inspection and assess compliance with the legislation and minimum standards.

There was evidence of good practice concerning staff recruitment; authorised operator training; safeguarding; laser safety; the management of the patients' care pathway; the management of medical emergencies; infection prevention and control (IPC); the adherence to best practice guidance in relation to COVID-19; the management of clinical records; effective communication between patients and staff; and the organisational and clinical governance arrangements.

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

No immediate concerns were identified regarding the delivery of front line patient care.

3.0 How we inspect

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

The information obtained is then considered before a determination is made on whether the clinic is operating in accordance with the relevant legislation and minimum standards. Examples of good practice are acknowledged and any areas for improvement are discussed with the person in charge and detailed in the Quality Improvement Plan (QIP).

4.0 What people told us about the service?

Posters were issued to the service by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire.

Seven patients and one relative/visitor questionnaires were submitted to RQIA prior to the inspection. All respondents indicated that they felt that the care was safe, effective, that patients were treated with compassion and that the service was well led. All also indicated that they were very satisfied with each of these areas of care. Six patient responses included very positive comments pertaining to the high standard of customer service and care delivered. As patients were not present on the day of the inspection patient feedback was further assessed by reviewing the most recent patient satisfaction surveys compiled by Cathedral Eye Clinic.

The clinic actively seeks the views of patients about the quality of care, treatment and other services provided. Patient feedback regarding the service was found to be very positive in all aspects of care received and it reflected that the team deliver a very high standard of care.

5.0 The inspection

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

Areas for improvement from the last inspection on 16 March 2021		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 39 (2) **Stated:** First time	The registered person shall ensure only authorised operators use the lasers.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.8.	
Area for improvement 2 **Ref:** Regulation 39 (2) **Stated:** First time	The registered person shall formalise the authorising of operators and ensure it is carried out by a suitably qualified individual, such as the Clinical Director.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.8.	
Area for improvement 3 **Ref:** Regulation 28 (2) **Stated:** First time	The registered person should ensure that any notifiable event is notified to RQIA within 24 hours of the event occurring.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.8.	

Action required to ensure compliance with Minimum Care Standards for Independent Healthcare Clinics (July 2014)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 13.1 **Stated:** First time	The registered person shall ensure that a robust system is developed to ensure that all staff (including those with practising privileges) undertake mandatory training in keeping with the RQIA training guidance.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.1.	
Area for Improvement 2 **Ref:** Standard 20.2 **Stated:** First time	The registered person shall amend IPC policies and procedures to reflect Covid-19 best practice guidance	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.9.	
Area for Improvement 3 **Ref:** Standard 48.6 **Stated:** First time	The registered person shall ensure the local rules for the Quantel Fusion refer to the unit's correct laser classification which is a Class 3b laser.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.8.	
Area for Improvement 4 **Ref:** Standard 48.6 **Stated:** First time	The registered person shall ensure all authorised operators and persons involved in the laser service sign that they have read and understood the local rules.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.8.	

Area for Improvement 5 **Ref:** Standard 48.15 **Stated:** First time	The registered person shall ensure the LPS role is strengthened with the full implementation of the responsibilities of the LPS to ensure robust laser safety arrangements.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.8.	
Area for Improvement 6 **Ref:** Standard 8 **Stated:** First time	The registered person shall ensure correction fluid is not used in records required under the regulations.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.8.	
Area for Improvement 7 **Ref:** Standard 48.16 **Stated:** First time	The registered person shall ensure laser warning signs are displayed when the laser is in use as outlined in the Local Rules.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.8.	
Area for Improvement 8 **Ref:** Standard 11.4 **Stated:** First time	The registered person shall further develop the practising privileges agreement to ensure each medical practitioner's specific scope of practice is documented.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.9.	

5.2 Inspection outcome

5.2.1 How does this service ensure that staffing levels are safe to meet the needs of patients and staff are appropriately trained to fulfil the duties of their role?

Staffing arrangements were reviewed and it was confirmed that there are appropriately skilled and qualified staff involved in the delivery of services. This includes a team of consultant ophthalmologists, consultant anaesthetists, optometrists, registered nurses and laser technicians who have evidence of specialist qualifications and skills in refractive laser eye surgery.

The clinic staff take part in ongoing training to update their knowledge and skills, relevant to their role. Induction programmes relevant to roles and responsibilities are required to be completed when new staff join the team. A review of records evidenced that new staff members had completed an induction programme following commencement of employment.

A system was in place to monitor all aspects of ongoing professional development and a record was retained of all training and professional development activities. A review of the records confirmed that all staff, including those with practising privileges, had undertaken training in keeping with RQIA training guidance and legislation. It was determined that the previous area for improvement 1 made against the standards, as outlined in section 5.1, had been met.

Discussion with Mr McArdle and review of documentation identified that arrangements were in place to check the registration status for all clinical staff on appointment and on an ongoing basis. The arrangements for monitoring the professional indemnity of all staff was also in place, as was a system for the monitoring of any practicing privileges (further in section 5.2.9).

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

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

5.2.2 How does the service ensure that recruitment and selection procedures are safe?

The arrangements in respect of the recruitment and selection of staff were reviewed.

A review of three personnel files of staff recruited since the previous inspection and discussion with Mr McArdle confirmed that new staff have been recruited as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005.

A recruitment policy and procedure was in place which was comprehensive and reflected best practice guidance.

The staff register reviewed was found to be up to date and included the names and details of all staff who are and have been employed, in keeping with legislation.

Robust recruitment and selection procedures were in place to ensure compliance with the legislation and best practice guidance.

5.2.3 How does the service ensure that it is equipped to manage a safeguarding issue should it arise?

Mr McArdle stated that treatments are not provided to persons under the age of 18 years.

Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. 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 were included for onward referral to the local Health and Social Care (HSC) Trust should a safeguarding issue arise.

Discussion with staff confirmed that they were aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified.

Review of records demonstrated that all staff had received training in safeguarding adults as outlined in the Minimum Care Standards for Independent Healthcare Clinics July 2014. Ms Quinn, as the safeguarding lead, had completed formal training in safeguarding adults in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016) and minimum standards.

It was confirmed that a copy of the regional guidance document entitled Adult Safeguarding Prevention and Protection in Partnership (July 2015) was available for reference.

The service had appropriate arrangements in place to manage a safeguarding issue should it arise.

5.2.4 How does the service ensure that medical emergency procedures are safe?

The arrangements in respect of the management of medical emergencies were reviewed.

A review of records confirmed that protocols were available to guide the team on how to manage recognised medical emergencies. A review of the resuscitation policy identified that this policy did not accurately reflect the robust arrangements that were found to be in place for managing a medical emergency. Advice was provided on the matter and on 7 March 2022 RQIA received confirmation from Mr McArdle that a re-devised medical emergency policy and procedure had been implemented.

The British National Formulary (BNF) and the Resuscitation Council (UK) specify the emergency medicines and medical emergency equipment that must be available to safely and effectively manage a medical emergency.

Review of the emergency trolley found robust systems were in place to ensure that emergency medicines and equipment do not exceed their expiry date and are immediately available. It was noted that there were two automated external defibrillator(AED) available within the clinic, one located at the main reception area and another located in the lens bank room.
There was signage displayed throughout the clinic advising of the location of the AEDs and the emergency trolley. In addition an endophthalmitis treatment box was in place to allow rapid access to treatment.

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

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.

Review of the arrangements to manage a medical emergency identified that staff were suitably trained and appropriate medicines and equipment were in place to manage a medical emergency should one arise.

5.2.5 How does the service ensure that it adheres to infection prevention and control and decontamination procedures?

The arrangements for IPC procedures throughout the clinic were reviewed to evidence that the risk of infection transmission to patients, visitors and staff was minimised. There were IPC policies and procedures in place that were in keeping with best practice guidance.

A tour of the premises was undertaken and the clinic was found to be clean, tidy and uncluttered. Cleaning schedules were in place and records were completed and up to date. Staff described the procedure to decontaminate the environment and equipment between patients and this was in keeping with best practice.

A review of training records confirmed that staff had received IPC training commensurate with their roles and responsibilities. Staff spoken with on inspection demonstrated good knowledge and understanding of all IPC procedures.

Personal protective equipment (PPE) was readily available in keeping with best practice guidance and according to the treatments provided. The laser suite provided dedicated hand washing facilities and hand sanitiser was available throughout the clinic.

The service had appropriate arrangements in place in relation to IPC and decontamination.

5.2.6 Are arrangements in place to minimise the risk of COVID-19 transmission?

COVID-19 has been declared as a public health emergency and we all need to assess and manage the risks of COVID-19, and in particular, businesses need to consider the risks to their patients and staff.

The management of operations in response to the COVID-19 pandemic were discussed with Mr McArdle and staff who outlined the measures that will be taken by Cathedral Eye Clinic to ensure current best practice measures are in place.

Appropriate arrangements are in place in relation to maintaining social distancing; implementation of enhanced IPC procedures; and the patient pathway to include COVID-19 screening prior to attending appointments.

Infection prevention and control (IPC) policies and procedures were in place, it was confirmed that current Covid-19 best practice guidance and the measures were included and were clearly outlined. It was determined previous area for improvement 2 made against the standards, as outlined in section 5.1, had been met

The management of COVID-19 was in line with best practice guidance and it was determined that appropriate actions had been taken in this regard.

5.2.7 How does the service ensure that laser procedures are safe?

The arrangements in respect of the safe use of the laser equipment were reviewed.

A laser safety was in place and was found to contain all of the relevant information pertaining to the lasers in place. There was written confirmation of the appointment and duties of a certified LPA. The service level agreement between the clinic and the LPA is reviewed on an annual basis and was seen to be up to date.

The clinic's LPA completed a remote risk assessment of the premises on 18 January 2022, review of the risk assessment report evidenced that no recommendations had been made.

As previously discussed refractive laser eye procedures are only carried out by the consultant ophthalmologists acting as the clinical authorised operators and are supported by laser technicians acting as non-clinical authorised operators. Training records in place demonstrated that each consultant ophthalmologist had completed appropriate training for the specific laser(s) that they are authorised to use and had been signed off by the clinical director. It was demonstrated that a robust process has been established to ensure that each consultant ophthalmologist has been formally authorised by the clinical director to use a specific laser(s). It was determined that previous areas for improvement 1 and 2 made against the regulations, as outlined in section 5.1, have been met.

It was evidenced that laser surgical eye procedures are carried out by consultant ophthalmologists in accordance with medical treatment protocols produced by three resident consultant ophthalmologists. Systems were in place to review the medical treatment protocols on an annual basis.

Up to date local rules were in place which have been developed by the LPA; these contained the relevant information pertaining to the laser equipment being used. Arrangements were in place to review the local rules on an annual basis. Records reviewed demonstrated all authorised operators and persons involved in the laser service had signed to confirm that they have read and understood the relevant local rules. It was determined that previous areas for improvement 3 and 4 made against the standards, as outlined in section 5.1, have been met.

When the laser equipment is in use, the safety of all persons in the controlled area is the responsibility of the LPS. We discussed the role of the LPS and their responsibilities. An area of improvement had been made against the standards, at the previous inspection, to strengthen the LPS role with the full implementation of the responsibilities of the LPS to ensure robust laser safety arrangements. This was discussed with Mr McArdle who informed us that following the previous inspection a suitably qualified and experienced staff member had been appointed as the LPS. However the identified staff member has since resigned. Mr McArdle stated the clinic is in the process of appointing a new LPS.

On 11 April 2022 RQIA received email correspondence from Mr McArdle which provided written confirmation that Ms Gillian Murdoch had been formally appointed as the new LPS. It was determined that previous areas for improvement 5 made against the standards, as outlined in section 5.1, have been met.

As previously discussed a review of training records confirmed that both clinical and non-clinical authorised operators had up to date training in core of knowledge; basic life support; infection prevention and control; fire safety awareness; and safeguarding adults at risk of harm in keeping with the RQIA training guidance.

It was evidenced that an individual laser surgical register was maintained in respect of each laser and was completed each time the respective laser is operated. It was good to note that correction fluid was not used in these records. It was therefore determined previous area for improvement 6 made against the standards, as outlined in section 5.1, had been met. It was identified that one of the laser surgical registers did not record the patient's full first name, and recorded only the patient's first initial, followed by the patient's surname. It was advised that each patient's full first name and surname should be recorded to reduce the risk of miss-identification. On 7 March 2022, RQIA received email correspondence confirming that all five laser surgical registers now include each patient's full first name and surname.

The laser suites where the laser equipment is used was found to be safe and controlled to protect other persons while treatment is in progress. Mr McArdle confirmed that 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 lasers are operated using keys and passwords that unauthorised staff do not have access to and there were arrangements in place in relation to the safe custody of the keys and passwords of the laser equipment.

Mr McArdle confirmed that protective eyewear was available for non-clinical authorised operators if required. A review of the eyewear evidenced that it was provided as outlined by the LPA in the local rules.

The laser safety warning signs are illuminated outside of the laser suite when the laser is in use and turned off when not in use, as described within the local rules. It was determined that previous area for improvement 7 made against the standards, as outlined in section 5.1, had been met.

Arrangements have been established for equipment to be serviced and maintained in line with the manufacturers' guidance. The most recent service reports reviewed were and outlined various dates of completion in the last year.

Carbon dioxide (CO2) fire extinguishers, suitable for electrical fires were available in the clinic and arrangements were in place to ensure the fire extinguishers are serviced, in keeping with manufacturer's instruction.

5.2.8 How does the clinic ensure patients have a planned programme of care and have sufficient information to consent to treatment?

Mr McArdle confirmed that all patients have an initial consultation with an optometrist who discusses their treatment options and the cost of the surgery.

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

The clinic 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.

In accordance with General Medical Council (GMC) and the Royal College of Ophthalmologists guidance, patients meet with their surgeon on a separate day in advance of surgery, to discuss their individual treatment and any concerns they may have. They also meet the surgeon again on the day of surgery to complete the consent process for surgery.

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 also provided with clear post-operative instructions along with contact details if they experience any concerns. Systems were in place to refer patients directly to the consultant ophthalmologist if necessary.

Staff informed us that systems were in place to review the patient following surgery at one day, one week, one month, three months and longer if necessary.

Three patient care records reviewed were found to be well documented, contemporaneous and clearly outlined the patient journey.

It was determined that appropriate arrangements were in place to ensure patients have a planned programme of care and have sufficient information to consent to treatment.

5.2.9 Are robust arrangements in place regarding clinical and organisational governance?

Organisational governance

Various aspects of the organisational and medical governance systems were reviewed and evidenced a clear organisational structure within Cathedral Eye Clinic. As previously outlined, Mr Jonathan Moore is the responsible individual in the clinic and Mr McArdle is the registered manager .

Where the business entity operating a refractive eye service is a corporate body or partnership or an individual owner who is not in day to day management of the service, unannounced quality monitoring visits by the registered provider, or person acting on their behalf, must be undertaken and documented every six months; as required by Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005. Mr Moore works as a consultant ophthalmologist and acts as the clinical director for the service and is supported by Mr McArdle who oversees the day to day operation of services. It was established that Mr Moore, remains in day to day charge of the service, therefore the unannounced quality monitoring visits by the registered provider were not applicable.

There is programme of weekly meetings that take which includes all departments within the clinic; meeting minutes detail the outcomes with time limited actions and the identified persons to address each action point.

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

Policies and procedures were available for staff reference.

Staff working in different roles within the clinic confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Clinical and medical governance

As previously discussed, a team of consultant ophthalmologists, consultant anaesthetists, optometrists, registered nurses and laser technicians who have evidence of specialist qualifications and skills in refractive laser eye surgery.

The clinical governance committee meet quarterly; these meetings are chaired by the clinical director and are attended by consultant ophthalmologists and Mr McArdle. On discussion it was evident that the clinical governance committee meetings fulfil the function of a medical advisory committee (MAC) as outlined in Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments (July 2014). However terms of reference or standard agenda to evidence the function of a MAC were not available. It was advised that the clinical governance committee meetings should be formalised to clearly outline the role and function the MAC and ensure terms of reference in accordance with Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments (July 2014) are provided.

On 7 March 2022 RQIA received email correspondence from Mr McArdle confirming that the clinic are selecting appropriate individuals who will form the MAC and the terms of reference of the MAC in accordance Standard 30 were set out. RQIA were also advised that the clinical governance committee will be more condensed, with the minutes and outcomes imparted to the clinical team and the departmental management team. The clinical governance lead will chair these meetings and lead on the resultant outcomes. Cathedral Eye Clinic is to be commended for their swift response to progress this area.

Three consultant ophthalmologists are considered to be wholly private doctors as they no longer hold a substantive post in the Health and Social Care (HSC) sector in Northern Ireland (NI) and are not on the General Practitioner's (GP's) performer list in NI. Review of the three consultant ophthalmologists' details confirmed evidence of the following:

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

As previously discussed all consultant ophthalmologist had completed training in accordance with RQIAs training guidance for private doctors and are aware of their responsibilities under GMC Good Medical Practice.

All medical practitioners working within the clinic must have a designated Responsible Officer (RO). A RO is an experienced senior doctor who works with the GMC to make sure doctors are reviewing their work. In accordance with the GMC all doctors must revalidate every five years. The revalidation process requires doctors to collect examples of their work to understand what they're doing well and how they can improve. As part of the revalidation process RO's make a revalidation recommendation to the GMC. Where concerns are raised regarding a doctor's practice information must be shared with their RO who then has a responsibility to share this information with all relevant stakeholders in all areas of the doctor's work. The consultant ophthalmologist working within the clinic has a designated external RO due to their prescribed connection with another health care organisation and has revalidated accordingly.

Practising Privileges

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

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

A practising privileges policy and procedure was in place which outlined the arrangements for the application, granting, maintenance, suspension and withdrawal of practising privileges. Mr McArdle outlined the process for granting practising privileges and told us the medical practitioner would meet with Mr Moore prior to practising privileges being granted.

A review of records and evidenced that there was a written agreement between each medical practitioner and Cathedral Eye Clinic setting out the terms and conditions which had been signed by both parties. We found that all practising privileges agreements had been reviewed within the previous two years and clearly stated each medical practitioner's scope of practice. It was determined that the previous area for improvement 1 made against the standards, as outlined in section 5.1, had been met.

Quality assurance

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

The results of audits are analysed and actions identified for improvement are embedded into practice. If required, an action plan is developed to address any shortfalls identified during the audit process.

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 Statement of Purpose and Patient's Guide were kept under review, revised and updated when necessary and available on request.

The RQIA certificate of registration was up to date and displayed appropriately and current insurance policies were in place.

Notifiable Events/Incidents

A robust system was in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies as appropriate.

Mr McArdle confirmed that any learning from incidents would be discussed with staff. There was a process in place for analysing incidents and events to detect potential or actual trends or weakness in a particular area in order that a prompt and effective response can be considered at the earliest opportunity. An audit would be maintained, reviewed and the findings presented to the directors during their quarterly meetings.

A review of notifiable event submitted to RQIA since the previous inspection demonstrated compliance with legislation and best practice guidance. It was determined that previous area for improvement 3 made against the regulations, as outlined in section 5.1, has been met.

Complaints Management

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

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

It was confirmed that no written complaints had been received since the previous inspection. Mr McArdle advised that any complaints received would be investigated and responded to appropriately to include details of all communications with complainants; the result of any investigation; the outcome and any action taken. Information gathered from complaints will be used to improve the quality of services provided.

Overall, the governance structures within the clinic provided the required level of assurance to the senior management team and the MAC.

5.2.10 Does the service have suitable arrangements in place to record equality data?

The arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients was discussed with Mr McArdle and staff.

Discussion and review of information evidenced that the equality data collected was managed in line with best practice.

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mr McArdle, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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