Announced Care Inspection Report
7 February 2019

Cathedral Eye Clinic

Service Type: Independent Hospital (IH) – Laser Eye Surgery
Address: 89-91 Academy Street, Belfast, BT1 2LS
Tel No: 028 9032 2020
Inspectors: Carmel McKeegan, Winifred Maguire and Norma Munn
RQIA's Medical Physics Advisor: Dr Ian Gillan

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 an independent hospital providing laser eye surgery.

Laser equipment

Floor 1 YAG Room

Manufacturer: Quantel Medical
Model: Optimis 2
Serial Number: 54-15-029
Output wavelength: 1064nm
Laser Class: 4

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)	Mr Andrew Spence
Authorised Operators - the exception of the DORC.EVA laser)	Professor Jonathan Moore – All laser equipment (with
	Mr Colin Willoughby - Lumenis Selecta II SLT Mr. Sri Kamalarajah - Nd: Yag laser Ms Tanya Moutray - Nd:Yag laser Mr Richard Best - DORC EVA laser Mr Wing Chan - DORC EVA laser & Nd:Yag laser
Medical Support Services:	Professor Jonathan Moore Mr Richard Best (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

3.0 Service details

Organisation/Registered Provider: Cathedral Eye Clinic Ltd **Responsible Individual:** Mr Jonathan Moore	**Registered Manager:** Mr Gary McArdle
Person in charge at the time of inspection: Mr Gary McArdle	**Date manager registered:** 18 July 2017
Categories of care: Independent Hospital (IH) – AH (DS) Acute hospitals (day surgery only) PT(L) Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers PD Private Doctor	

4.0 Inspection summary

An announced inspection took place on 7 February 2019 from 10.00 to 16.30.

The inspector was accompanied by Dr Ian Gillan, RQIA's Medical Physics Advisor. The findings and report of Dr Gillan are appended to this report.

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 (DOH) 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.

Examples of good practice were evidenced in all four domains. These related to: patient safety in respect of staff training and development; safeguarding; infection prevention and control; laser safety arrangements; the management of medical emergencies; and the environment. Other examples included: the management of the patients' care pathway; communication; records management and engagement to enhance the patients' experience.

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	0	0

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

4.2 Action/enforcement taken following the most recent care inspection dated 20 February 2018

Other than those actions detailed in the quality improvement plan (QIP) no further actions were required to be taken following the most recent inspection on 20 February 2018.

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 previous care inspection report
- the returned QIP from the previous care inspection

Questionnaires were provided to patients prior to the inspection by the establishment on behalf of RQIA. Returned completed patient questionnaires were analysed prior to the inspection. RQIA invited staff to complete an electronic questionnaire prior to the inspection. No completed staff questionnaires were received by RQIA prior to or following the inspection.

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

During the inspection the inspectors met briefly with Mr Jonathan Moore, responsible individual. Mr Gary McArdle, registered manager, facilitated the inspection and the inspectors also met with a senior nurse and a senior optometrist who acts as the laser protection supervisor (LPS). 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 section
- safeguarding
- laser safety
- management of medical emergencies
- infection prevention and control
- care pathway
- communication
- management and governance arrangements
- practising privileges
- 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 Mr McArdle at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 20 February 2018

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 20 Febuary 2018

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 (2) (a) **Stated:** First time	The registered person shall ensure that all authorised operators have evidence of up to date training in core of knowledge, application training for the equipment in use, basic life support, infection prevention and control, fire safety and safeguarding adults.	**Met**

	Action taken as confirmed during the inspection: Mr McArdle confirmed he was aware of the RQIA mandatory training requirements and training undertaken by all staff is recorded on a training matrix. Review of the training matrix identified some deficits in training. Mr McArdle stated that some of the consultants had completed training elsewhere and had not yet provided a copy of their training certificates. On 15 February 2019 RQIA received written confirmation that Mr McArdle had received a copy of the training certificates for the identified individuals.	
Area for improvement 2 **Ref:** Regulation 19 (1) **Stated:** First time	The registered person shall ensure that the following up to date information is sought and retained for each consultant ophthalmologist: • 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	**Met**
	Action taken as confirmed during the inspection: Discussion with Mr McArdle and review of documents confirmed that in general the above documents were in place for each consultant ophthalmologist working in the establishment. It was identified that appraisal documents were not in place for two consultants, however on 15 February 2019 RQIA received written confirmation that appraisal records had been provided by the consultants and were retained in the clinic.	

Action required to ensure compliance with Minimum Care Standards for Independent Healthcare Establishments (July 2014)		Validation of compliance
Area for improvement 1 **Ref**: Standard 48.4 **Stated:** First time	The registered person shall ensure that the local rules include the following: • details of the room where each laser is used • the number of pairs of protective eyewear for each laser.	**Met**
	Action taken as confirmed during the inspection: Review of the local rules and controlled areas confirmed that the issues previously identified have been fully addressed.	
Area for improvement 2 **Ref**: Standard 48.20 **Stated:** First time	The registered person shall ensure that written procedures are devised detailing the arrangements for testing and servicing the lasers that have been unused for extended periods of time to enable them to return to clinical use.	**Met**
	Action taken as confirmed during the inspection: It was confirmed that a written procedure is in place which outlines the arrangements for testing and servicing any laser that has been unused for extended periods of time to enable it to return to clinical use. It was established that one laser has been removed from service; this laser was stored in a locked room. Mr McArdle confirmed that arrangements are in place to have this laser removed from the premises.	
Area for improvement 3 **Ref**: Standard 11.5 **Stated:** First time	The registered person shall ensure that practising privileges agreements are reviewed at least every two years.	**Met**
	Action taken as confirmed during the inspection: Review of seven medical practitioner's records confirmed that practising privileges agreements were in place and had been reviewed within the last two years. It was identified that one agreement record had not been signed by both parties. On 15 February 2019, RQIA received written confirmation that this practising privileges agreement had been signed by both parties.	

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

Discussion with Mr Mc Ardle and staff 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 specialist qualifications and skills in laser eye surgery.

Mr McArdle confirmed that laser eye procedures are only carried out by trained medical practitioners acting as clinical authorised operators and laser technicians /surgical assistants acting as non-clinical authorised operators. A register of clinical and non-clinical authorised operators for the laser is maintained and kept up to date. A staff register was in place.

A review of completed induction programmes for two staff evidenced that induction training is provided on commencement of employment.

A record of training undertaken by all staff is retained in a training matrix. Review of the training matrix evidenced that mandatory training in core of knowledge, application training for the equipment in use, basic life support, infection prevention and control and fire safety has either been completed or a planned date for provision of training is arranged. Mr McArdle demonstrated awareness of the RQIA mandatory training requirements for the service and had established arrangements in place to ensure all staff meet their training requirements.

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 there are rigorous systems in place for undertaking, recording and monitoring all aspects of staff supervision, appraisal and ongoing professional development.

A review of seven 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
- ongoing annual appraisal by a trained medical appraiser

- an appointed responsible officer
- arrangements for revalidation

As previously stated it was identified that appraisal documents were not in place for two consultants, however on 15 February 2019 RQIA received written confirmation that appraisal records had been provided by the identified consultants and were retained in the clinic.

Recruitment and selection

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.

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 staff in the establishment had received training in safeguarding children and adults as outlined in the Minimum Care Standards for Independent Healthcare Establishments July 2014. It was confirmed that the safeguarding lead has completed formal training in safeguarding adults in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016).

Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm.

The policy 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.

It was confirmed that copies of the regional policy entitled ‘Co-operating to Safeguard Children and Young People in Northern Ireland’ (August 2017) and the regional guidance document entitled ‘Adult Safeguarding Prevention and Protection in Partnership’ (July 2015) were both available for staff reference.

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 which is reviewed on an annual basis. The service level agreement between the establishment and the LPA was reviewed and this expires on August 2019.

Laser eye surgical procedures are carried out by trained medical practitioners in accordance with medical treatment protocols produced and reviewed in September 2018 by the Professor Jonathan Moore for all laser procedures with the exception of vitrectomy procedures. Medical treatment protocols for vitrectomy procedures have been devised by Mr Richard Best in December 2018. 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 relevant information pertaining to the laser equipment being used.

The establishment's LPA completed a risk assessment of the premises on 5 February 2019. All recommendations made by the LPA have been addressed.

A list of clinical and non-clinical authorised operators is maintained and authorised operators 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 operator 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 operators are aware who the LPS on duty is.

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 rooms 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 keys. Arrangements are in place for the safe custody of the laser keys 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.

The establishment has a laser surgical register for each laser 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 them to be comprehensively completed.

There are arrangements in place to service and maintain the laser equipment in line with the manufacturer's guidance. The most recent service reports were reviewed as part of the inspection process. Inspectors were informed that one laser is not operational, this laser was stored within a locked room and arrangements had been made to have the laser removed from the premises.

Dr Ian Gillan, RQIA's Medical Physics Advisor, reviewed the laser protection arrangements of the establishment and concluded they were of a high standard. Dr Gillan's report is appended to this inspection report.

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.

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. It was confirmed the Ulster Hospital provide sterile services to the establishment.

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

An external IPC audit had been carried out and action plan had been implemented to address the recommendations made.

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 very good infection control practices are embedded in the establishment.

Environment

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

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

Carbon dioxide (CO2) fire extinguishers were available which have been serviced within the last year.

Arrangements are in place for maintaining the environment.

A legionella risk assessment has been undertaken and water temperatures are monitored and recorded as recommended.

A fire risk assessment had been undertaken and staff confirmed fire training and fire drills had been completed. Staff demonstrated that they were aware of the action to take in the event of a fire.

Areas of good practice

There were examples of good practice found in relation to staff induction, training, supervision and appraisal, safeguarding, management of medical emergencies, infection prevention control and decontamination procedures and the environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Areas for improvement	0	0

6.5 Is care effective?

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

Care pathway

Patients have an initial consultation with a qualified optometrist or consultant ophthalmologist 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.

Staff 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 and a senior nurse if they experience any concerns. There are systems in place for the senior optometrist or the senior nurse 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 in accordance to the specific medical treatment protocol.

Six 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

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.

Areas of good practice

There were examples of good practice found in relation to the completion of clinical records, the arrangements for records management and ensuring effective communication between patients and staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Areas for improvement	0	0

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 involvement with decision making

Discussion with Mr McArdle and staff 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 rooms.

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 filing 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 and the results of these are 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.

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 and providing relevant information to allow patients to make informed choices.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
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

There was a clear organisational structure within the establishment and staff were able to describe their 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.

Mr McArdle is the nominated individual with overall responsibility for the day to day management of the service. Professor Jonathan Moore, responsible individual, is a consultant ophthalmologist who acts as the clinical director for the service. There are weekly clinic meetings with time limited actions and identifiable persons for these actions. Quarterly surgical governance meetings are held and are chaired by the clinical director and are attended by the consultant ophthalmologists and Mr McArdle.

Policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, dated and systematically reviewed on an annual 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. Mr McArdle demonstrated good awareness of complaints management. Mr McArdle demonstrated a good awareness of complaints management and was proactive in dealing with any expression of dissatisfaction.

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. Mr McArdle discussed a recent incident outside of the premises and it was agreed that Mr McArdle would submit a notification in this regard, which was received by RQIA on 8 February 2019.

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.

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 if required an action plan is developed and embedded into practice to address any shortfalls identified during the audit process.

Mr McArdle outlined the process for granting practising privileges and confirmed that medical practitioners meet with Mr Moore, responsible individual, prior to privileges being granted. As previously discussed a review of seven medical practitioner's records confirmed that practising privileges agreements were in place and had been reviewed within the last two years. It was identified that one agreement record had not been signed by both parties. On 15 February 2019, RQIA received written confirmation that this practising privileges agreement had been signed by both parties. The inspectors advised that the practising privileges agreement should also include each medical practitioner's scope of practice; Mr Mc Ardle was very receptive to this advice and confirmed that this will be included in all subsequent practising privileges agreements.

There are systems in place to review practising privileges agreements every two years.

A policy and procedure was in place 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.

Mr McArdle demonstrated a clear understanding of his 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 Client'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.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Areas for improvement	0	0

6.8 Equality data

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 which indicated that the equality data collected was managed in line with best practice.

6.9 Patient and staff views

Twenty patients submitted questionnaire responses to RQIA. All 20 patients indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led. All 20 patients also indicated that they were very satisfied with each of these areas of their care. The following comments were included in submitted questionnaires:

- 'Very good'
- 'I am very satisfied with the outcome of my surgery.'
- 'I have only just started treatment so I have no strong opinion yet.'
- 'Very good service from Cathedral. Procedure well managed on the day and aftercare very thorough.'

RQIA also invited staff to complete an electronic questionnaire prior to the inspection. No completed staff questionnaires were received.

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a quality improvement plan (QIP) is not required or included, as part of this inspection report.

8th February 2019

Ms Carmel McKeegan
Regulation & Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Dear Ms McKeegan

Laser Protection Report

The Cathedral Eye Clinic
88 - 91 Academy Street, Belfast BT1 2LS

Introduction

Further to yesterday's visit to the above premises, this report summarises the main Laser Protection aspects where improvement may be required. The findings are based on the requirements of European Standards and the Control of Artificial Optical Radiation at Work Regulations (Northern Ireland) 2010.

Notes / Comments
The Laser safety arrangements are of a high standard. No significant deficiencies were noted on the day of the inspection.

Dr Ian Gillan
Laser Protection Adviser to RQIA

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Appendix

Laser Systems:- The Cathedral Eye Clinic, Academy Street, Belfast

Floor 1 YAG Room

Manufacturer:	Quantel Medical
Model:	Optimis 2
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Output wavelength:	1064nm
Laser Class:	4

Manufacturer:	Quantel Medical
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Serial Number:	3434
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Manufacturer:	Zeiss
Model	VISUMAX
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Output wavelength:	1043nm
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Floor 2 Cataract Suite

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

Laser Protection Adviser
Anna Bass, Lasermet *Date of last visit February 2019*

The Regulation and Quality Improvement Authority

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