THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY

FAILURE TO COMPLY NOTICE

Name of Registered Establishment or Agency:	**FTC Ref:**
Laserway Laser Clinic	FTC/IHC-PT(L)-PT(IL)/11990/2015-16/01
Address of Registered Establishment or Agency:	
82 Lower Mill Street, Ballymena, BT43 5AF	
Name of Registered Person:	**Issue Date:**
Ms Imelda Barrett	17 February 2016

Regulation not complied with:

The Independent Health Care Regulations (Northern Ireland) 2005

39 (2) The registered person shall ensure that such a laser or intense light source is used in or for the purposes of the hospital only by a person who has undertaken appropriate training and has demonstrated an understanding of –

(a) the correct use of the equipment in question;
(b) the risks associated with using a laser or intense light source;
(c) its biological and environmental effects;
(d) precautions to be taken before and during use of a laser or intense light source.

Specific failings to comply with regulations:

During the pre-registration follow-up inspection on 13 November 2013 it was identified that the protective eyewear available for the intense pulse light (IPL) equipment was of a lower level of protection than that recommended by your appointed Laser Protection Advisor (LPA). A requirement was made to address this.

The returned quality improvement plan (QIP) for this inspection indicated that the protective eyewear as recommended by your LPA had been ordered and that a copy of confirmation of approval would be forwarded to the Regulation and Quality Improvement Authority (RQIA).

During the announced inspection on 19 November 2014 a review of the protective eyewear available for the IPL equipment identified that the requirement in relation to eyewear had not been addressed. The requirement was stated for the second time. It was also identified that your LPA had completed a risk assessment of the premises on 20 August 2014 and that some of the recommendations made had not been fully addressed. A further requirement was made to ensure that all recommendations made by the appointed LPA are fully addressed.

The returned QIP from the inspection on 19 November 2014, signed by you, indicated that the requirements in relation to protective eyewear and the LPA risk assessment had been addressed.

During the announced inspection on 10 February 2016 a number of issues in relation to the laser/IPL equipment and procedures were identified that do not meet with best practice guidance.

It was identified that a risk assessment had been undertaken by your appointed LPA on the 29 October 2015. However, the risk assessment was not available for review. On further enquiry, it was identified that the report prepared by the LPA following their visit, which included recommendations, had never been received and there was no evidence that you had attempted to obtain this report. Subsequently, the actions required to address the recommendations made had not been addressed.

Issues in relation to protective eyewear were again identified. The protective eyewear available was of a lower level of protection than that which had been recommended by your appointed LPA. In addition to this, it was observed that the protective eyewear for use by clients and staff was damaged, and as a result of both of these issues the eyewear for use posed a potential risk to the health and safety of clients and staff.

During discussion with staff there was no evidence to confirm that they recognised that the issues identified with the protective eyewear posed a potential risk to both themselves and clients.

Despite having raised these matters with you previously during inspections, RQIA is concerned that the continued lack of progress to address issues identified during inspection poses a risk to clients and staff.

Action required to comply with regulations:

The registered person must ensure that all recommendations made by the appointed Laser Protection Advisor (LPA) are fully addressed, signed and dated on completion by the Laser Protection Supervisor (LPS).

The registered person must ensure that the protective eyewear for the laser/IPL equipment is of the same level of protection as outlined within the local rules produced by the LPA.

The registered person must ensure that the protective eyewear is maintained in accordance with the manufacturer's guidance.
The registered person must ensure that robust systems are implemented to ensure that defective equipment is identified, reported and repaired/replaced as required.

The registered person must ensure that all authorised users have completed training or update training in core of knowledge and the safe use and application of the laser/IPL equipment.

The registered person must ensure that the training provided is embedded into practice to ensure the health and safety of clients and staff is maintained.

The laser protection file must be reviewed to ensure it is up-to-date.

The registered person may make written representations to the Chief Executive of RQIA regarding the issue of a failure to comply notice, within one month of receipt of this notice.

Date by which compliance must be achieved is 23 March 2016.

Signed..... **Director of Regulation and Nursing**

This notice is made under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Independent Health Care Regulations (Northern Ireland) (2005)

It should be noted that failure to comply with some regulations is considered to be an offence and RQIA has the power under regulations to prosecute for specified offences.