

Inspection Report

26 and 27 February 2026



Kingsbridge Private Hospital North West

Type of service: Independent Hospital
Address: Church Hill House, Ballykelly, BT49 9HS
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www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 [Minimum Care Standards for Independent Healthcare Establishments \(July 2014\)](#)

1.0 Service information

Organisation/Registered Provider: Kingsbridge Healthcare Group Limited	Registered Manager: Mr Anthony McKenna
Responsible Individual: Mr Mark Regan	Date registered: 22 August 2022
Person in charge at the time of inspection: Mr Anthony McKenna	Number of registered places: 38 Inpatient beds 10 Day surgery beds
Categories of care: Acute Hospital Inpatient (AH) Acute Hospital Day surgery (AH-DS) Private Doctors (PD) Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers PT(L) Prescribed techniques or prescribed technology: establishments using endoscopy PT(E)	
Brief description of how the service operates: Kingsbridge Private Hospital North West (KPHNW) is registered with the Regulation and Quality Improvement Authority (RQIA) as an Independent Hospital with the categories of care as outlined above. KPHNW provides a wide range of surgical, medical and outpatient services for both adults and children. The hospital is registered to accommodate up to 38 patients as inpatients and 10 day surgery beds. The hospital has four main operating theatres, three of which have a laminar clean air system specifically designed for orthopaedic and ophthalmic surgery. The hospital also has a dedicated endoscopy suite; an x ray department and magnetic resonance imaging (MRI) scanner; a central sterile services department (CSSD); and a range of consulting rooms. The day surgery rooms and the inpatient accommodation, which includes facilities dedicated paediatric for accommodation, are situated on the ground floor of the hospital. Outpatient services are provided at the Liz Dallas Building located within the hospital grounds. Kingsbridge Healthcare Group Limited is the registered provider for three Independent Hospitals registered with RQIA. Mr Mark Regan is the Responsible Individual for Kingsbridge Healthcare Group Limited.	

Equipment available in the service:**Laser Suite**

Manufacturer: Ceram Optec Bioletic
 Model: Cerelas E
 Serial Number: 4291-G
 Laser Class: 4
 Wavelength: 1470 ± 30 nm

Manufacturer: Zeiss
 Model: Visulas YAG III
 Serial Number: 1272074
 Laser Class: 4
 Wavelength: 1064nm

Types of treatment provided:

Vascular treatments using Cerelas E
 Capsulotomy procedures using Visulas YAG III

2.0 Inspection summary

A short notice announced inspection was undertaken to the KPHNW on 26 and 27 February 2026.

The onsite care component of the inspection was undertaken by one senior inspector and four care inspectors on 26 and 27 February 2026. The RQIA inspectors were supported on the 26 February 2026 by RQIA's appointed laser protection advisor (LPA) and a medical practitioner who is an ADEPT (Achieve Develop Explore Programme for Trainees) fellow.

RQIA's LPA reviewed the laser equipment and the laser safety arrangements. Their report containing their findings and recommendations is appended to this report. Following this inspection, RQIA received evidence which confirmed that all recommendations identified by RQIA's LPA have been actioned. Further detail is provided in section 5.2.5 of this report.

This inspection focused on four key themes: organisational and clinical governance; staffing arrangements; the management of the general surgery patients' care pathway and the laser safety arrangements.

Examples of good practice were evidenced in 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 and engagement to enhance the patients' experience.

A variation to registration application to add the Liz Dallas Building to the KBPHNW registration was approved during December 2025.

No immediate concerns were identified regarding patient safety.

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 days of the inspection.

Prior to the inspection we reviewed a range of information relevant to the hospital. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the hospital
- written and verbal communication received since the previous care inspection
- the previous care inspection report.

The inspection team undertook a tour of the premises and the inspection was facilitated by Mr McKenna and other staff members.

The inspection team spoke with; Mr Regan; Mr McKenna; the medical director; a resident medical officer (RMO), the theatre manager; two theatre nursing staff; an operating department practitioner; the post anaesthesia care unit (PACU) manager; a recovery nurse; an inpatient unit ward sister; two inpatient unit deputy sisters; three inpatient unit staff nurses; a wound care nurse and members of the hospital liaison team.

The information obtained is then considered before a determination is made on whether the establishment 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 QIP.

4.0 What people told us about the service?

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

No patients or relatives/visitors submitted responses.

Three staff submitted questionnaire responses. Overall, staff indicated that patient care was effective and that patients were treated with compassion. Responses in relation to the provision of safe care were mixed, with two staff expressing dissatisfaction. All three staff responses indicated a level of dissatisfaction in relation to whether the service was well led. The three staff responses included comments. Whilst one staff member did note a high standard of patient care, another raised concerns regarding the scheduling of staff breaks and finishing times particularly for night shift staff. It was also suggested that greater transparency would be beneficial in relation to providing staff with access to inspection reports and opportunities to discuss the inspection report with their team leaders.

On the day of inspection, the inspection team spoke with staff who described a positive and supportive working environment. They felt staffing levels were safe and were sufficient to meet patient needs. Although the wards can be busy, staff did not feel this impacted on safety or the quality of care provided.

Infection prevention and control practices were described as good, and staff felt they had the right skills and training for their roles, with access to further development opportunities.

Management was described as supportive and approachable, helping to create an open culture where staff felt listened to. Staff spoke positively about teamwork, describing close working relationships and effective communication within the team and across the wider multidisciplinary team, including physiotherapists, RMOs, and medical staff. Doctors and anaesthetists were also described as approachable and easy to communicate with.

The inspection team spoke with two inpatients who described a very positive experience of care throughout their hospital stay. They highlighted the consistently high quality of care provided by all staff, from pre-admission through to post-surgery and discharge planning. Staff were described as friendly, attentive and unhurried, with all staff introducing themselves and taking time to support patients appropriately. Clinical care was praised, with no concern raised regarding wound healing or pain management, and patients reported prompt responses from nursing staff when assistance was required. Additional aspects of care, including physiotherapy input, were described as excellent. Patients also spoke highly with regards to the variety of food on offer, noting it was nutritious and that staff were accommodating to individual requests. Overall, both patients felt they received excellent, well-coordinated care.

Overall, staff described a strong team culture with good peer support, effective multidisciplinary working, and a positive work–life balance, with everyone working well together to deliver high quality care.

5.0 The inspection

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

The last care inspection to KPHNW was undertaken on 19 and 20 March 2025

Areas for improvement from the last inspection on 19 March 2025		
Action required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments (July 2014)		Validation of compliance
Area for improvement 1 Ref: Standard 32.5 Stated: First time	The responsible individual shall ensure scheduling of patients for surgical procedures takes into account the patient requirements for the entire patient pathway, staffing levels, the nature of the surgical procedure, facilities and equipment available and any associated risks. The scheduling must have meaningful involvement of the medical and nursing staff.	Met
	Action taken as confirmed during the inspection: It was confirmed that the scheduling of patients for surgical procedures has meaningful involvement of the medical and nursing staff. This area of improvement has been met. The matter is further outlined in section 5.2.4 of this report.	

5.2 Inspection findings

5.2.1 Governance and Leadership

Organisational Governance

Various aspects of the organisational and medical governance systems were reviewed and evidenced a clear organisational structure within KPHNW.

KPHNW is part of the Kingsbridge Healthcare Group (KHG) and is supported by well-established governance arrangements.

A review of the Governance and Compliance Strategy and Framework 2025 demonstrated that the KHG has developed a robust governance model that involves a network of quality teams operating through all levels and disciplines within the organisation. These teams allow for communication throughout the organisation ensuring a steady flow of information.

Each hospital has a local management team (LMT) who meet weekly with departmental heads to report and discuss on clinical governance and compliance issues such as complaints, incidents and learning outcomes with action plans and timeframes.

The local governance and quality team (LGQT) meet monthly to discuss and work through their local quality agenda.

Standing core agenda items include risk management and clinical effectiveness including incidents and complaints, audit, policy updates/ratification, appraisals, training and continuous professional development (CPD), patient and staff experience and quality management systems.

The LGQT will create action plans and will report to and seek advice from the Medical Advisory Committee (MAC) as required. The MAC is discussed in more detail in the next section of this report.

The LGQT provides upward and downward assurance within the KHG for the clinical governance and the local quality agenda. Attendees at the meeting are required to ensure appropriate cascade of information to staff groups. Minutes and action plans are circulated to members to facilitate discussion at local management and team meeting level.

A quarterly meeting of the administrative governance and quality team takes place. Attendees are representative departmental managers or leads from all areas of the KHG. The agenda for the group focuses on governance, quality key performance indicators (KPIs), risk management and education. The rolling agenda includes updates from every departmental manager regarding any group learning outcomes from complaints, incidents, trend analysis, audit findings, operational issues and business development issues. This group produces a quarterly and annual quality report to the Board.

The Competition and Markets Authority (CMA) requires that all hospitals and consultants offering private treatment submit data to the Private Healthcare Information Network (PHIN) as the Information Organisation for private healthcare. This provides people considering private healthcare with clear information to help them make an informed choice of which consultant and hospital is right for them.

We were informed that an electronic system for receiving patient experience feedback has been implemented which enables the KPHNW to feed into PHIN. There was also evidence of patient feedback being shared with staff as a means of continually evaluating and driving service improvement.

A range of policies and procedures were accessible and evidenced. Policies and procedures examined were in date with a planned review date recorded and they were retained in a way that is easily accessible to all staff. All policies and procedures are stored and accessed electronically.

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

Clinical and medical governance

The KHG Board of Directors (the Board) requires consultant medical practitioners to practice in accordance with the General Medical Council (GMC) guidance 'Good Medical Practice', completing appropriate appraisal and revalidation requirements and adhering to the KHG's practising privileges agreement.

As previously outlined, LGQT meet on a monthly basis and assist the Board in its oversight and integrity of KPH's clinical governance arrangements, including responsibilities regarding RQIA and the PHIN.

The duties of the LGQT include ensuring there is a mechanism for reporting and recording of all clinical incidents and to regularly review all such incidents to; consider issues of concern relating to the clinical practice of an individual, where identified, and bring to the attention of the MAC; review and monitor all complaints relating to clinical issues; have oversight and monitor the risk management system and controls in place and escalate any major risks identified to the Board; ensure the MAC is in receipt of all consultants practising privileges documentation; have oversight of the duties and responsibilities of the Resident Medical Officers and monitor their performance on a regular basis.

In conjunction with the MAC, the LGQT will identify areas appropriate for medical audit and will oversee these audits and outcomes.

Audits recently undertaken included: inpatient falls audit; patient complaints audit; breast surgery surgical site infection audit; as well as quarterly infection prevention and control audits.

In addition to the above, a number of management reports providing an overview of the orthopaedic and adenotonsillectomy procedures completed at KPHNW were available for review by inspectors. It was confirmed that audit findings, including IPC audit findings, are shared at the LMT and LGQT meetings and at the IPC steering group meetings.

The MAC meets quarterly with responsibility for surgeon performance and surgery specific matters. As discussed, the LGQT ensures that all the documentation for consultants with practising privileges are in place including checking registration with the GMC, professional indemnity and appraisals. Terms of reference for the MAC were in place and these have been developed in accordance with Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments (2014). It was evidenced that the MAC meetings have standing agenda items and are used as a forum to discuss clinical governance issues; the appointment and renewal of practising privileges agreements; the review of performance indicators; corrective action in relation to adverse clinical incidents; and any other untoward event or near miss. A review of MAC meeting minutes confirmed that these meetings were being undertaken on a quarterly basis in line with the criteria set out in Standard 30.

In accordance with the requirements of registration 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 are doing well and how they can improve.

Experienced senior doctors work as Responsible Officers (ROs) with the GMC to ensure doctors are reviewing their work. As part of the revalidation process, ROs make a revalidation recommendation to the GMC. It was established that KHG is registered with the GMC as a designated body and have an appointed RO.

A number of consultants are considered to be wholly private doctors as they are GMC registered doctors who do not have a prescribed connection to a RO within the HSC sector in Northern Ireland.

A review of a sample of three consultants' 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 the GMC
- ongoing annual appraisal by a trained Medical Appraiser
- an appointed RO
- arrangements for revalidation

Appraisal is a key part of revalidation and includes the appraisee providing evidence of their individual continuing professional development (CPD) activities undertaken in accordance with the GMC Good Medical Practice. A system was in place to record when appraisals have been received. If there has been a delay, the date the appraisal is expected to be submitted by is documented.

We reviewed the arrangements for the oversight and recording of induction and on-going training for consultants to ensure all consultants working in KPHNW receive mandatory training and other training, supervision and appraisal in accordance with best practice guidance. A training matrix for clinical staff evidenced a high compliance rates.

As previously discussed, training compliance rates are included in the quarterly LGQT and MAC meetings.

Practising Privileges

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

It was established that the majority of consultants who work in KPHNW are not directly employed and work under a practising privileges agreement.

A detailed policy and procedural guidance for the granting, review and withdrawal of practicing privileges agreements was in place. It was evidenced that this policy states that 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.

As previously discussed, a review of the practising privileges agreement confirmed that there is clear and accurate information regarding when annual appraisals should be submitted and clear escalation actions are outlined if annual appraisals are not submitted within the specified time.

It was also demonstrated that the practising privileges application now includes a requirement to demonstrate completion of specific areas of mandatory training and also ongoing registration with the Information Commissioner's Office (ICO). A practising privileges portal is being rolled out to enable medical practitioners to submit the required documentation electronically. This electronic system will also have the facility to issue reminders and other communications to medical practitioners.

It was demonstrated that practising privileges matters are discussed and reviewed during the MAC meetings.

Good oversight arrangements of the granting of practicing privileges agreements were in place and provided assurance of robust medical governance arrangements within the organisation.

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.

Significant incidents and themes reported are discussed during the LMT, LGCT and MAC meetings.

There was a robust programme for internal audit to monitor compliance with policies and processes. Audits are completed monthly, quarterly and annually as per the KHG's audit schedule. As previously discussed, the outcomes are monitored by the LGCT 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.

It was demonstrated that 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.

Notifiable Events/Incidents

The Governance and Compliance Strategy and Framework provides an overview of the mechanisms in place, and of roles and responsibilities at all levels throughout KPHNW, to oversee, report and respond to clinical risks, incidents and near misses. This includes reporting requirements to external bodies as required and arrangements for the management of national safety alerts. A Group Adverse Incident policy further describes the internal electronic reporting mechanism, which is accessible to all staff and corresponding investigation pathways following categorisation of the incident.

Review of meeting minutes and discussion with the management team confirmed that any learning from incidents would be cascaded to relevant staff members. 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.

As previously mentioned significant incidents and themes reported are discussed at the organisation's clinical governance meetings, the MAC and health and safety committees.

Complaints Management

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

Discussion with staff 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.

Review of the complaints log confirmed that all complaints received in the previous 12 months were investigated and responded to in line with the complaints policy. Details of all communications with complainants, any investigation undertaken and the resultant actions were documented. Any learning from the investigation of complaints is disseminated across all staff groups to drive improvement in the quality of the service.

A recent complaints audit was available for review during the inspection. The audit was up to date and capable of reflecting any themes emerging from complaints analysis.

The KPHNW management team described an effective governance structure that provides a process and system of accountability to support the delivery of good quality service and to monitor and maintain high standards of care.

5.2.2 Does the hospital have appropriately qualified and skilled staff in place?

The arrangements for the recruitment and selection of staff were reviewed. A recruitment policy and procedure was in place in keeping with legislation and best practice guidance.

The KHG training academy provides an ongoing training programme. All staff are facilitated and encouraged to take part in ongoing training to update their knowledge and skills, relevant to their role. The training academy provides Mr McKenna with a monthly update of completed staff training.

There are clear arrangements in place for resident medical cover through the role of the RMO.

An electronic 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 training matrix confirmed a high level of compliance. Staff had either completed or were in the process of completing training as outlined in the RQIA training guidance and legislation.

A sample of personnel files of newly recruited staff evidenced that relevant recruitment records had been sought; reviewed and stored as required. Induction programmes relevant to roles and responsibilities are required to be completed when new staff join the team. A review of records confirmed that the newly appointed authorised operators had completed a programme of induction.

Discussion with Mr McKenna, in conjunction with a review of documentation, confirmed that robust arrangements were in place to check the registration status for all clinical staff on appointment and twice yearly on an ongoing basis. The arrangement for monitoring the professional indemnity of all staff was also in place.

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

5.2.3 Are there safe practices in place for the day surgery and inpatient services?

The arrangements for the provision of day surgery and inpatient services as outlined in the statement of purpose and categories of care were reviewed.

Discussion with staff confirmed that referrals can be received from a patient's general practitioner (GP) or as part of the HSC waiting list initiative.

It was confirmed that patients are reviewed by a consultant, anaesthetist and a pre-operative nurse in the outpatient department prior to admission. Patients are provided with information regarding their treatment which includes the risks and benefits associated with their planned programme of care. It was also confirmed that interpreting services are arranged by the booking office when required.

There is a day procedure unit and an inpatient unit that is divided into two surgical wards.

The inspectors visited the inpatient wards and the day procedure unit where they observed care, spoke to staff and reviewed a number of patient records. The facilities and premises were found to be appropriate for the services that were delivered.

The day procedure unit contains outpatient pods next to the nurses' station. The pods function as a quiet, comfortable and private space for patient's pre and post procedure. The service takes account of the individual needs of children, young people and those close to them with dedicated rooms available and specialist paediatric nursing care.

It was evidenced that care is delivered in a co-ordinated way between the day procedure unit and theatres downstairs, creating an efficient patient flow through the outpatient service. The day procedure team is part of the daily emergency call safety huddle, which is a meeting that takes place every morning with allocated staff.

Discussion with an RMO and staff in the inpatient unit confirmed that on admission to the inpatient unit, patients are reviewed by nursing and medical staff who complete the patient pathway, including pre-operative checklists and risk assessments prior to the patient being transferred to the theatre department. Medical on call and escalation arrangements were confirmed.

Observations and discussion with staff confirmed that arrangements were in place to refer patients to other members of the multidisciplinary team based on the patient's assessed need.

It was confirmed that there is a planned programme for discharge in place and that patients are provided with a discharge letter which is shared with the patient's GP, a supply of medications, and written information with advice on managing their condition following their procedure. It was also confirmed that patients are provided with details regarding any outpatient review appointments prior to discharge. It was evidenced that information was available for patients to contact the service if they had concerns following discharge.

A sample of medical care records reviewed evidenced that they included a contemporaneous note of each patient's medical history, medicine regime, all treatment provided, and notes provided by medical and other health care providers involved in their care. Care records contained information relating to pre-operative, peri-operative, and post-operative care which clearly outlined the patient pathway.

A sample of nursing patient care records were reviewed and it was confirmed that a comprehensive assessment of their health care needs is completed using evidence based assessment tools. It was noted that patient care records included a contemporaneous note of each patient's medical history and treatment provided. However, it was identified that some patient care records were incomplete. This matter was discussed with Mr McKenna who provided assurances that this matter would be reviewed.

We observed that staff responded promptly to patient requests and that the privacy and dignity of patients was maintained. Discussion with staff confirmed that pain was assessed prior to routine practices, such as wound dressing and movement being performed. It was also confirmed that the pain management of each patient was a priority and that medical staff were readily available if further pain relief prescriptions were required. Discussion with staff confirmed that pain medication is administered as prescribed in the medicine Kardex and arrangements are in place for pain relief to be prescribed out of hours, if required. Staff confirmed they are adequately trained in medicines management and are competent in the administration of controlled drugs.

The management of wound care was discussed and it was confirmed that staff had a sound knowledge of wound management and the use of aseptic non-touch technique (ANTT). It was also confirmed that a supply of pressure relieving equipment can be procured if required.

There is a wound care clinic located in a dedicated room within the inpatient unit. It was confirmed that the clinic provides a wound management service for patients who have undergone surgical procedures within the hospital. Discussion with staff confirmed that arrangements are in place to refer patients, and that wound care appointments are booked by a team of dedicated wound care nurses. It was confirmed that support was available from medical staff and the hospital infection prevention and control (IPC) nurse as required.

Discussion with staff confirmed there is procedure for delivering bad news to patients and/or their representatives. Conversations with staff confirmed that this procedure was in accordance with the Breaking Bad News Regional Guidelines (2003).

A range of emergency trolleys containing emergency medicines and equipment are readily accessible in the inpatient unit and day procedure unit. Emergency medicines were stored securely and oxygen was noted to be in date. There were separate adult and paediatric emergency medicines and equipment in place.

It was determined that safe practices were in place for the inpatient and day procedure services.

5.2.4 How does the service ensure that surgical services are safe?

The arrangements for the provision of surgical services in the hospital as outlined in the statement of purpose and categories of care were reviewed. The inspection team evidenced that these services operate in accordance with best practice and national standards to ensure care delivery is safe and effective.

It was confirmed that adult and paediatric surgical services are provided. The scheduling of patients for surgical procedures is co-ordinated by the booking office with senior management and the theatre manager's involvement. The theatre lists are required to take into account the individual requirements of the patient, the type of procedure to be performed, availability of equipment, staffing levels required, and any associated risks.

On the previous inspection, an area of improvement was identified concerning the scheduling of patients for surgical procedures. This matter was discussed with staff who told us that there was meaningful involvement of clinical staff from all areas in the weekly theatre planning meetings. Staff stated that this has led to improvements with regards to the safe scheduling of patients; appropriate staffing considerations; availability of required equipment and appropriate discharge planning envisioned for the aftercare of each patient. As previously outlined in section 5.1 this area of improvement has been met.

Prior to surgery, the patient is sent information about the procedure and any preparation necessary in advance, together with the consent form. The consent process is completed by the consultant carrying out the procedure as part of the admission process.

Staff confirmed that there will be an identified member of nursing staff, with relevant experience, in charge during all surgical procedures which is formally recorded. Staff complete a surgical safety checklist based on World Health Organisation (WHO) guidance and completion of the surgical checklist and compliance is routinely audited through the hospital's auditing process.

It was confirmed that patients are observed during and after the surgery procedures by appropriately trained staff. Surgical patients are transferred to the ward area in accordance with recovery area discharge criteria by the nursing staff. It was confirmed that if there were any concerns about the patient's condition, the consultant would be immediately informed for ongoing management.

A surgical register for each theatre was in place. A review of a number of surgical registers noted that they were well completed in accordance with regulation.

It was confirmed that surgical assistants are used in the hospital. A written log and an electronic log is maintained to confirm they have been granted practising privileges with a defined scope of practice for their participation in specific surgery. The surgical assistants have practising privileges with the hospital and operate within a defined scope of practice. This is further discussed in section 5.2.1 of this report.

KPHNW has an EN ISO 13485 certified Hospital Sterilisation and Decontamination Unit (HSDU) on site. This HSDU supplies sterile instrument packs for surgical procedures. There are robust measures in place to monitor the traceability of all surgical instruments used in the hospital.

Clinical equipment was evidenced to be clean and fit for purpose, and traceability labels were used to identify when equipment had been cleaned.

A wide range of comprehensive policies and procedures were in place to ensure that safe and effective care is provided to patients, in accordance with good practice guidelines and national standards. Management confirmed that they were currently reviewing all policies and procedures.

There were procedures for the collection, labelling, storage, preservation, transport and administration of specimens. Staff clearly described these procedures and the procedure for reporting results to the appropriate clinical staff and GPs. It was confirmed that there is a contract in place with a pathology laboratory service. The pathology services are subject to internal audit. A range of emergency trolleys containing emergency medicines and equipment are readily accessible in the theatre and recovery area. Each trolley is checked daily by nursing staff. Emergency medicines were stored securely and oxygen was noted to be in date. There were separate adult and paediatric emergency medicines and equipment in place.

Medical emergencies were discussed and this included the management of a massive blood loss emergency. It was noted that a change had been made to the management of a massive blood loss emergency protocol. This change was reflective of an agreed management plan for the management of a massive blood loss emergency that had been agreed by the Western Health and Social Care Trust (WH SCT) and KPHNW. All the necessary protocols had been devised and training had been provided to relevant staff with regards to the protocol changes. However, a paediatric massive blood loss protocol was not in place. Management gave assurances to devise this protocol with the involvement of appropriately qualified paediatric staff.

Theatre management confirmed that joint replacement information is provided for the National Joint Registry (NJR) with the consent of patients. The hospital also participates in the Breast and Cosmetic Implant Registry (BCIR). The BCIR register was established to enable the identification of trends, complications relating to implants, and to ensure patients could be traced in the event of a product recall or other safety concern. Review of completed documentation in relation to NJR and BCIR noted that they were well completed. During the inspection, advice was provided to carry out an implant pathway audit to review the robustness of the process. At the conclusion of the inspection, it was very positive to note the governance team had devised an implant pathway audit. The theatre manager confirmed the audit would be fully integrated in the theatre audit programme.

Patients are observed during surgery and in the recovery room, and the hospital had discharge criteria in place to confirm when patients were well enough to leave theatre recovery and to transfer to the ward area.

It was determined that safe practices were in place for delivery of surgery services and the area of improvement outlined will consolidate this approach.

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

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

A laser safety policy and procedure is in place. Following discussion with Mr McKenna, it was confirmed that the laser safety file would be updated to include the electronic location of the laser safety policy to ensure it was readily accessible.

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 vascular surgeons and supporting staff, which include registered nurses and health care assistants.

As discussed in section 5.2.1 and in conjunction with a review of documentation, it was confirmed that robust arrangements were in place to check the registration status for all clinical staff on appointment and on an ongoing basis.

A review of the laser safety files found that they contained relevant information in relation to the laser equipment in place. There were arrangements in place confirming the support and duties of a certified LPA.

All patients have an initial consultation with a consultant ophthalmologist or vascular surgeon who discusses their treatment options and the cost of the surgery. A list of fees is available for each type of surgical procedure provided.

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

In accordance with GMC and the Royal College of Ophthalmologists guidance, patient's 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. Arrangements are in place to review the patient following surgery.

A number of 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.

It was confirmed that laser capsulotomy procedures are only carried out by one of five consultant ophthalmologists, acting as the clinical authorised operators for the YAG laser, and two consultant vascular surgeons who are authorised to use the Cerelas laser for vascular procedures. A separate clinical authorised operator register was in place for each laser in use. The registers were maintained and kept up to date.

KPHNW's LPA completed a risk assessment of the premises and the laser safety arrangements, and provided a laser safety report. Mr McKenna was advised to review the recommendations made by the LPA in both documents to ensure all matters have been addressed. Mr McKenna gave us assurances this matter would be addressed following the inspection.

It was confirmed that laser vascular and YAG Capsulotomy procedures are undertaken in accordance with medical treatment protocols produced by a named medical practitioner. It was noted that the YAG laser treatment protocol, which had been updated during February 2023, had not yet been signed by the clinical authorised operators. This matter was discussed with Mr McKenna and following the inspection RQIA received evidence that this matter had been addressed. Review of the Endovenous laser ablation (EVLA) treatment protocol noted that it had not been signed by one clinical authorised operator. Following the inspection RQIA received evidence that this matter had been addressed.

Advice and guidance was provided to Mr McKenna to ensure that the timescale for review of the medical treatment protocols corresponded with that stated in the LPA report. Following the inspection RQIA received evidence that this matter had been addressed.

Up to date local rules were in place which have been developed by the LPA and 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. Advice and guidance was provided to Mr McKenna to ensure that the document management fields in the local rules are signed and dated. Following the inspection RQIA received confirmation that this matter had been addressed.

Review of the local rules evidenced that they had not been signed by all supporting staff. Following the inspection Mr McKenna confirmed that this matter had been addressed. The local rules included the following:

- the potential hazards associated with lasers
- controlled and safe access
- authorised operators' responsibilities
- methods of safe working
- safety checks
- personal protective equipment
- prevention of use by unauthorised persons
- adverse incident procedures

When the laser equipment is in use, the safety of all persons in the controlled area is the responsibility of the LPS. KPHNW had an appointed LPS.

A review of training records confirmed that all clinical 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. Records confirming clinical authorised operators had undertaken application training for the Ceram Optec Bioletic laser were available for review during the inspection. It was identified that clinical authorised operator's application training records for the Visulas YAG laser were not retained in the laser safety folder and were held electronically.

Mr McKenna was advised that the laser safety file should include copies of training records, or a documented reference providing electronic links to these training records. Mr McKenna gave us assurances this matter would be addressed following the inspection.

It was confirmed that laser safety training for assisting staff was retained electronically. Mr McKenna gave us assurances that links to the electronic training records would be included in the laser safety file.

Further advice and guidance was provided to Mr McKenna to provide laser safety awareness training for all other staff working in the department, but not directly involved in the use of the laser equipment. Following the inspection RQIA received confirmation that this matter was being addressed.

Two dedicated laser surgical registers were in place, one for each laser in use.

The laser registers in place included:

- the name of the person treated
- the date
- the operator
- the treatment given
- the precise exposure given
- any accidents or adverse incidents

Advice and guidance was provided to Mr McKenna to ensure the laser registers are fully maintained every time the laser is operated. Following the inspection RQIA received confirmation that this matter had been addressed.

The identified theatre (controlled area) where the laser equipment is used was found to be safe and controlled to protect other persons while treatment is in progress. It was confirmed that the doors to the controlled area 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 robust arrangements in place in relation to the safe custody of the keys and passwords for the laser equipment.

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 identified theatre when the laser equipment is in use and turned off when not in use, as described within the local rules.

Arrangements have been established for equipment to be serviced and maintained in line with the manufacturers' guidance. The most recent service report for the Ceram Optec Bioletic and Visulas YAG lasers was reviewed.

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

As a result of the actions taken during and following the inspection, it was determined that appropriate arrangements were in place to operate the laser equipment.

6.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. The findings of the inspection were discussed with Mr Mark Regan, Responsible Individual and Mr Anthony McKenna, Registered Manager, the medical director and other members of the KHG as part of the inspection process and can be found in the main body of the report.

Appendix 1

17 April 2026

Laser Protection Report**Site Details:**

Kingsbridge Private Hospital North West
 Church Hill House
 Main St
 Ballykelly
 Limavady
 BT49 9HS

Laser Protection Adviser appointed by site: Phil Loan, One Photon Ltd

Laser/IPL Equipment:

Make	Model	Class	Serial Number	Wavelength(s)
Ceram Optec Bioletic	Cerelas E	4	4291-G	1470 ± 30nm
Zeiss	Visulas YAG III	4	1272074	1064nm

Introduction

A Laser Protection Adviser (LPA) inspection of Kingsbridge Private Hospital North West was performed on 26 February 2026. This report summarises the main aspects of the inspection and document review where improvements may be required. The findings are based on the requirements of the Minimum Care Standards for Independent Healthcare Establishments published July 2014 by the Department of Health, Social Services and Public Safety (DHSSPSNI) and other relevant legislation, guidance notes and European Standards.

The LPA inspection included a review of protective eyewear, environment/signage, training records and user authorisation, laser device markings, maintenance records, treatment protocols, risk assessments, local rules, appointment of duty holders (LPS/LPA).

Comments & Recommendations:**1. Laser Treatment Protocols:**

- a. Following the recent update to the YAG laser treatment protocol on 23 February 2026, the clinic should ensure that Authorised Users provide signed confirmation that they understand and accept the revised protocol.
- b. One of the authorised users had not signed the EVLA Treatment Protocol. The clinic should ensure that all authorised users provide signed confirmation that they understand and accept the revised protocol.

2. Risk Assessment and LPA Report:

The clinic should complete and sign off all actions from the risk assessment and LPA report, prioritising those in bold, such as maintaining accurate records of laser training.

3. Local Rules:

During the inspection it was noted that the document management fields within the Local Rules had not been signed. It is recommended that the Local Rules are formally signed to confirm authorisation, approval, and document control in accordance with local governance arrangements.

4. Laser Treatment Register:

The clinic should ensure that all fields in the laser treatment register are correctly completed each time as specified in headers.

5. Policy – Use of Lasers within KPHNW:

During the inspection it was noted that although the laser safety policy was referenced in the laser safety file, a copy of the policy is not held within the file itself. The clinic advised that the laser safety policy is maintained electronically only. It is therefore recommended that the laser safety file includes a clear note identifying the electronic location of the policy to ensure it can be readily accessed when required.

6. Training Records:

- a. YAG laser Authorised Users; During the inspection it was noted that application training records for authorised users of the YAG laser were not available within the laser safety file. It is recommended that the laser safety file includes either copies of the relevant application training records or a clear reference to their electronic location, to demonstrate that all authorised users have completed appropriate training.
- b. Laser safety training; Copies of training records of the laser safety for assisting staff and laser safety awareness training were not present within the laser safety file at the time of inspection. The clinic confirmed that these records are maintained electronically. It is recommended that the laser safety file is updated to include copies of these records or a documented reference to their electronic storage location to ensure they are readily accessible for audit and inspection purposes.

The clinic should inform RQIA when the above points have been addressed.



Mrs Jane Brown
Laser Protection Adviser to RQIA

Post Inspection Update:

The clinic has provided the following updates:

- Point 1b: The authorised user has now signed the EVLA treatment protocol.
- Point 3: The document management fields within the Local Rules have now been completed and the document has been formally signed.



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