Inspection Report

30 September 2025

Musgrave House Healthcare Limited

Type of service: Independent Clinic (IC) - Private Doctor
Address: 10 Stockman's Lane, Belfast, BT9 7JA
Telephone number: 028 9560 7020

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: Musgrave House Healthcare Limited **Responsible Individual:** Mr Sean McGovern	**Registered Manager:** Mrs Isabel Stone **Date registered:** 18 June 2025
Person in charge at the time of inspection: Ms Isabel Stone	**Categories of care:** Independent Clinic (IC) - Private Doctor
Brief description of the accommodation/how the service operates: Musgrave House Healthcare Limited is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent clinic (IC) with a private doctor (PD) category of care. Prior to the inspection, RQIA received an application to change the registered provider of the service to Musgrave House Medical Consulting Ltd. This application will be reviewed separately. A private doctor is a General Medical Council registered doctor who does not have a prescribed connection to a Responsible Officer within the Health and Social Care (HSC) sector in Northern Ireland. Musgrave House Healthcare Limited offers outpatient clinics in the following medical specialities: orthopaedics; psychiatry; emergency medicine and medico-legal reviews. This inspection focused solely on the arrangements for providing private doctor services that fall within regulated activity and the category of care for which the establishment is registered.	

2.0 Inspection summary

This was an announced inspection, undertaken by two care inspectors on 30 September 2025 from 10.00 am to 3.00 pm.

It focused on the themes for the 2025/26 inspection year. The purpose of the inspection was to assess progress with areas for improvement identified during the last care inspection and to assess compliance with the legislation and minimum standards.

There was evidence of good practice concerning patient safety in respect of staffing; staff training; safeguarding; management of medical emergencies; infection prevention and control (IPC); the environment; records management. Other examples included the management of the patients' care pathway; patient confidentiality; communication; governance arrangements and ensuring the core values of privacy and dignity were upheld.

One area for improvement has been stated for a second time against the standards; to ensure the written agreement between each private doctor and the establishment defines the scope of practice in which the private doctor may treat patients.

One area for improvement has been identified against the regulations in relation to the recruitment and selection of staff.

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

3.0 How we inspect

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

The information obtained is then considered before a determination is made on whether the clinic is operating in accordance with the relevant legislation and minimum standards.

Examples of good practice are acknowledged and any areas for improvement are discussed with the person in charge and detailed in the quality improvement plan (QIP).

4.0 What people told us about the service

We issued posters to the registered provider prior to the inspection inviting patients and members of staff to complete an electronic questionnaire.

Twenty patients and one relative submitted responses. Patient responses, in the main, indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led and that they were either satisfied or very satisfied with each of these areas of their care. Two patients indicated level of dissatisfaction across a number of areas of care. This was discussed with Ms Stone following the inspection. A number of patient responses included positive comments pertaining to the friendliness and professionalism of staff and the service provided.

Five staff members and 13 visiting professionals submitted questionnaire responses. The staff and visiting professionals' responses indicated that, in the main, they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. All staff and visiting professionals indicated that they were very satisfied with each of these areas of patient care with the exception of one staff member, who indicated that they were neither satisfied nor dissatisfied that care is effective. A number of staff/ visiting professionals' responses included positive comments pertaining to the approachability and supportive staff and the running of the service.

5.0 The inspection

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

Areas for improvement from the last inspection on 10 December 2024		
Action required to ensure compliance with Minimum Care Standards for Independent Healthcare Establishments (July 2014)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 11.4 and 11.5 **Stated:** First time	The responsible individual shall ensure there is a written agreement between each private doctor and the establishment that sets out the terms and conditions of the practising privileges of each private doctor and defines the scope of practice in which the private doctor may treat patients. Evidence of the written agreement for each private doctor should be submitted on return of this quality improvement plan (QIP).	**Partially met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as partially met and further detailed is provided in section 5.2.9	

5.2 Inspection outcome

5.2.1 How does this service ensure that staffing levels are safe to meet the needs of patients and that staff are suitably trained?

The staffing arrangements in respect of Musgrave House Healthcare Limited were reviewed. As previously stated, a private doctor is a General Medical Council registered doctor who does not have a prescribed connection to a Responsible Officer within the Health and Social Care (HSC) sector in Northern Ireland. Ms Stone confirmed that two private doctors work in Musgrave House Healthcare Limited.

A review of the details of the private doctor records evidenced the following:

- current General Medical Council (GMC) registration
- qualifications in line with services 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

It was identified that confirmation of identity for both of the PDs and evidence of professional indemnity insurance for one of the PDs was not available for review. This was discussed with Ms Stone and following the inspection, RQIA received evidence that these records were in place.

It was confirmed that both private doctors are aware of their responsibilities under GMC Good Medical Practice.

A review of a sample of training records evidenced that staff had completed basic life support, IPC, fire safety awareness and safeguarding adults at risk of harm training in keeping with RQIA training guidance.

Through discussion and review of relevant documentation, it was confirmed that there were rigorous systems in place for undertaking, recording, and monitoring all aspects of staff supervision, appraisal, and ongoing professional development.

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

It was demonstrated that staffing levels are safe and staff are appropriately trained to meet the needs of patients.

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

There were recruitment and selection policies and procedures in place that adhered to legislation and best practice guidance.

Ms Stone oversees recruitment and selection of staff and approves all staff appointments. Discussion with Ms Stone confirmed that she had a clear understanding of the legislation and best practice guidance.

Registered establishments are required to maintain a staff register. A review of the staff register evidenced that three new staff had been recruited since the previous inspection. A review of a sample of personnel files of newly recruited staff evidenced that, in the main, relevant recruitment records had been sought; reviewed and stored as required. Ms Stone was provided with advice and guidance regarding matters which required further attention. Following the inspection, RQIA received confirmation that these matters had been addressed.

It was noted that a number of enhanced Access NI disclosure checks had been obtained after staff had commenced employment in the clinic. This was discussed with Ms Stone and an area for improvement against the regulations has been made in this regard.

There was evidence of induction checklists for the different staff roles. A review of records confirmed that if a professional qualification is a requirement of the post, a registration check is made with the appropriate professional regulatory body.

Addressing the area for improvement will ensure there are robust recruitment and selection procedures in place that adhere to the legislation and best practice guidance to ensure suitably skilled and qualified staff work in the clinic.

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

A policy and procedure was 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 were included for onward referral to the local Health and Social Care Trust should a safeguarding issue arise.

Discussion with Ms Stone confirmed that she was aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified.

Review of records demonstrated that Ms Stone, as the safeguarding lead, has completed formal level three training in safeguarding adults in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016) and minimum standards.

Following the inspection, RQIA received confirmation that a copy of the regional policy entitled Co-operating to Safeguard Children and Young People in Northern Ireland (November 2024) and the regional guidance document entitled Adult Safeguarding Prevention and Protection in Partnership (July 2015) were available for reference.

It was determined that the service had appropriate arrangements in place to manage a safeguarding issue should it arise.

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

There was a medical emergency policy and procedure in place and a review of this evidenced that it reflected legislation and best practice guidance.

Systems were in place to ensure that emergency medicines and equipment are immediately available as specified in the clinic's policy and do not exceed their expiry dates.

Managing medical emergencies is included in the induction programme and refresher training is undertaken annually.

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

It was determined that the service had appropriate arrangements in place to manage a medical emergency.

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

The IPC arrangements were reviewed throughout the establishment to evidence that the risk of infection transmission to patients, visitors and staff was minimised.

There was an overarching IPC policy and associated procedures in place. A review of these documents demonstrated that they were comprehensive and reflected legislation and best practice guidance.

The consultation room reviewed was clean and clutter free. Discussion with Ms Stone evidenced that appropriate procedures were in place for the decontamination of equipment between uses. Cleaning schedules for the establishment were in place.

Hand washing facilities were available and adequate supplies of personal protective equipment (PPE) were provided. As discussed previously, staff had up to date training in IPC.
Ms Stone is aware that the Department of Health (DOH) and Public Health Agency (PHA) websites provide advisory information, guidance and alerts with regards to IPC.

It was determined that the service had appropriate arrangements in place in relation to IPC and decontamination.

5.2.6 How does the service ensure the environment is safe?

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

The most recent fire risk assessment had been undertaken during February 2025.

It was determined that appropriate arrangements were in place to maintain the environment.

5.2.7 Are records being effectively managed?

The arrangements for the management of records were reviewed to ensure that records are managed in keeping with legislation and best practice guidance.

Review of documentation confirmed that the establishment had a policy and procedure in place for the management of records. The policy reviewed included the arrangements for the creation; use; storage; transfer; disposal of and access to records in keeping with best practice guidance and legislative requirements.

Ms Stone confirmed that she was aware of the importance of effective records management and that records are held in line with best practice guidance and legislative requirements.

The patient pathway was discussed with Ms Stone who stated that a record is retained for patients who attend Musgrave House Healthcare Limited.

It was confirmed that each private doctor is responsible for maintaining clinical records in accordance with GMC guidance and Good Medical Practice. It was confirmed that all patients' clinical records are stored securely and can be located if required.

The establishment is registered with the Information Commissioner's Office (ICO).

Discussion with Ms Stone and review of the management of records policy confirmed that patients have the right to apply for access to their clinical records in accordance with the General Data Protection Regulations that came into effect during May 2018 and where appropriate ICO regulations and Freedom of Information legislation.

It was determined that clinical records are managed in accordance with legislation and best practice guidance.

5.2.8 How does the service ensure that patients are treated with dignity and respect and are involved in the decision making process?

Discussion with Ms Stone regarding the consultation and treatment process confirmed that patients are treated with dignity and respect.

The consultations and treatments are provided in private consultation rooms. If required, information is provided to the patient during their consultation to allow patients to make choices about their care and treatment and provide informed consent.

Ms Stone told us that patients are provided with the opportunity to complete a satisfaction survey. Results are collated to provide an anonymised summary report which is made available to patients and other interested parties. Ms Stone confirmed that an action plan would be developed to inform and improve services provided, if appropriate.

Appropriate measures are in place to treat patients with dignity and respect and to ensure they have sufficient information to make informed decisions.

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

Organisational Governance
Where the business entity operating the service is a corporate body or partnership or an individual owner who is not in day to day management of the clinic, unannounced quality monitoring visits by the registered provider must be undertaken and documented every six months; as required by Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005.

Ms Stone is the nominated individual with overall responsibility for the day to day management of the clinic and is responsible for reporting to the registered person. Advice and guidance was provided to Ms Stone to ensure that the registered person or person acting on their behalf monitors the quality of services and undertakes a visit to the premises at least every six months in accordance with legislation.

Ms Stone was receptive to this advice and following the inspection, RQIA received a copy of the unannounced monitoring visit report along with any identified actions. Ms Stone confirmed that the unannounced monitoring visits will be completed every six months in keeping with legislation.

Medical Governance and Practising Privileges
The only mechanism for a clinician to work in a registered independent clinic is either under a practising privileges agreement or through direct employment by the establishment. 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.

Review of documentation confirmed that the establishment had a policy and procedure in place for the granting, review and withdrawal of practicing privileges agreements.

There was a written agreement between each medical practitioner and Musgrave House Healthcare Limited that sets out the terms and conditions of granting practising privileges, however it was noted that it did not outline the scope of practice in which each PD may treat patients. This was discussed with Mr McGovern who confirmed that practising privileges agreements would be updated with the defined scope of practice in which each PD may treat patients. It was determined that the previous area for improvement 1, made against the standards, as outlined in section 5.1, has been partially met and has been restated for a second time.

Arrangements were in place to review each of the practising privileges agreements every two years or more frequently if required.

Mr McGovern confirmed that the Board of Directors meet quarterly to discuss the key performance indicators and any issues identified within the establishment.

Advice and guidance was provided to implement Medical Advisory Committee (MAC) meetings for the clinic. Following the inspection, RQIA received confirmation of the arrangements to address this matter.

A review of the terms of reference for the MAC confirmed that the MAC will meet quarterly and there are arrangements in place for extraordinary meetings where necessary.

Complaints Management
The arrangements for the management of complaints and incidents were reviewed to ensure that they were being managed in keeping with legislation and best practice guidance.

The complaints policy and procedure provided clear instructions for patients and staff to follow. Patients were made aware of how to make a complaint by way of the patient's guide.

Arrangements were in place to record any complaint received in a complaints register and retain all relevant records including details of any investigation undertaken, all communication with complainants, the outcome of the complaint and the complainant's level of satisfaction.

A review of records concerning complaints evidenced that complaints had been managed in accordance with best practice guidance. It was confirmed that arrangements are in place to audit complaints to identify trends, drive quality improvement and to enhance service provision.

Notifiable Events/Incidents
Discussion with Ms Stone confirmed that an incident policy and procedure was in place. Following the inspection, RQIA received evidence that the incident policy has been updated to include the reporting arrangements to RQIA. Ms Stone confirmed that arrangements are in place to effectively document and investigate incidents in line with legislation. All relevant incidents are reported to RQIA and other relevant organisations in accordance with legislation and RQIA Statutory Notification of Incidents and Deaths. Arrangements are in place to audit adverse incidents to identify trends and improve service provided.

Quality Assurance
Policies and procedures were available outlining the arrangements associated with the Musgrave House Healthcare Limited. Observations made confirmed that policies and procedures were indexed, dated and systematically reviewed on a three yearly basis or more frequently if required.

Ms Stone demonstrated a clear understanding of her role and responsibility in accordance with legislation.

Ms Stone confirmed that the statement of purpose and patient's guide are kept under review, revised and updated when necessary and available on request.

The RQIA certificate of registration was displayed in a prominent place.

Observation of insurance documentation and discussion with Ms Stone confirmed that current insurance policies were in place.

Addressing the area for improvement will ensure that suitable arrangements are in place to enable the registered person to assure themselves of the quality of the services provided.

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

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

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with **The Independent Health Care Regulations (Northern Ireland) 2005** and the **Minimum Care Standards for Independent Healthcare Establishments (July 2014).**

	Regulations	Standards
Total number of Areas for Improvement	1	1*

*The total number of areas for improvement includes one that have been stated for a second time.
Areas for improvement and details of the QIP were discussed with Ms Stone, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 19 (2) Schedule 2, as amended **Stated:** First time **To be completed by:** 30 September 2025	The registered person shall ensure that an enhanced Access NI disclosure check is sought and reviewed with the outcome recorded prior to any member of staff commencing employment in the future. Ref: 5.2.2
	Response by registered person detailing the actions taken: Practice Manager fully aware of Access NI procedure and will ensure Access NI is sought prior to commencement of employment.
Action required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments (July 2014)	
Area for improvement 1 **Ref:** Standard 11.4 and 11.5 **Stated:** Second time **To be completed by:** 15 December 2025	The responsible individual shall ensure there is a written agreement between each private doctor and the establishment that sets out the terms and conditions of the practising privileges of each private doctor and defines the scope of practice in which the private doctor may treat patients. Evidence of the written agreement for each private doctor should be submitted on return of this quality improvement plan (QIP). Ref 5.2.9

	Response by registered person detailing the actions taken: 2 x Practice Privileges have been completed by Dr Ray Paul and Dr Mangan - 2 yearly review in place. Both copies have been sent to the Inspector Jenyth Gorzalska on 03 Dec 25.

Please ensure this document is completed in full and returned via Web Portal

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