The Regulation and Quality Improvement Authority

Inspection Report

6 June 2024

Hillsborough Private Clinic

Type of service: Independent Hospital – Surgical Services
Address: Cromlyn, 2 Main Street, Hillsborough BT26 6AE
Telephone: 028 9268 8899

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

1.0 Service information

Organisation/Registered Provider: Cromlyn House Surgical Ltd **Responsible Individual:** Mr Gary McKee	**Registered Manager:** Ms Thelma Weir, acting manager **Date registered:** Awaiting registered manager application
Person in charge at the time of inspection: Ms Thelma Weir	
Categories of care: Acute Hospital (Day Surgery) - AH(DS) Endoscopy - PT(E) Laser - PT(L) Private Doctor - PD	
Brief description of how the service operates: Hillsborough Private Clinic is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital with acute hospitals (day surgery only) AH (DS); prescribed techniques or prescribed technology: establishments providing endoscopy services PT(E); laser services PT(L) and private doctor (PD) categories of care. Hillsborough Private Clinic provides a wide range of services and treatments, including outpatient services across a range of medical specialties; diagnostic tests and investigations including endoscopy services; surgical day case procedures and laser eye procedures. Cromlyn House Surgical Ltd is part of the Affidea Group which also owns and operates Orthoderm Clinic and Affidea Belfast, also registered with RQIA. **Laser equipment** Manufacturer: Nidek Model: YC-1800 Laser Class: 3B Wave Length: Nd YAG 1064nm Serial Number: Y1650186 **Clinical authorised operators**: Seven named consultant ophthalmologists **Types of treatment provided**: Laser eye surgery-capsulotomy and Iridectomy	

2.0 Inspection summary

A short notice announced inspection was undertaken to Hillsborough Private Clinic (HPC) which commenced with an onsite inspection on 6 June 2024 from 10.00 am to 4.00 pm and included a request for the submission of information electronically.

The onsite component of the inspection was completed on 6 June 2024 by three care inspectors. Feedback of the onsite inspection findings was delivered to the Hillsborough Private Clinic management team on the day of the inspection.

RQIA's Laser Protection Advisor (LPA) accompanied the inspectors and reviewed the laser equipment and the laser safety arrangements. Their findings and recommendations are appended to this report.

The electronic submission of additional documentation in relation to the premises aspect of the inspection was reviewed remotely by an RQIA estates inspector and feedback was provided to the registered person following the inspection.

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

Examples of good practice were evidenced in patient safety in respect of the management of the patients' care pathway and engagement to enhance the patients' experience.

No concerns were identified in relation to patient safety and the inspection team noted areas of strength, particularly in relation to the delivery of front line 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.

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 and quality improvement plan (QIP).

One week prior to the onsite inspection the hospital was provided with a list of specific documents requesting items to be reviewed remotely in respect of the maintenance of the premises and grounds. These items were to be sent electronically to our estates inspector on or before 13 June 2024 for review remotely.

The inspection team undertook a tour of the premises and the inspection was facilitated by Ms Weir.

During the inspection we spoke with; Ms Weir, acting manager and clinical manager; the human resources (HR) and compliance manager; the clinic operations manager, Affidea Group; a senior nurse and a theatre nurse.

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 Hillsborough Private Clinic by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire. No completed staff or patient questionnaires were received prior to the inspection.

Through discussion with a number of staff who have differing roles and responsibilities it was determined that staffing levels and morale were good with evidence of good multidisciplinary team working and effective communication between staff.

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 30 August 2023		
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 11 **Stated:** Second time	The responsible persons shall strengthen their current systems to ensure they have an accurate and up to date position on medical appraisal status which clearly evidences reasons for delay, the decisions made and the time bound actions taken or any associated follow-up required for continued practicing privileges to be granted. The responsible persons shall provide confirmation to RQIA that all practitioner appraisals have been received by December 2023.	**Met**

	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.1.	
Area for Improvement 2 **Ref:** Standard 11 Standard 19 **Stated:** First time	The responsible persons shall ensure the Practicing Privileges Policy is reviewed and updated with subsequent appropriate ratification through the MAC. The policy should include; Accurate information on when annual appraisal should be submitted. Clear escalation actions are outlined if annual appraisals are not submitted within the specified time. This should identify clear timeframes and any assurances that may be sought to confirm the practitioner can continue to work in the clinic. Mandatory training requirements and any other training practitioners require to work in the clinic. The requirement for ongoing ICO registration should be clearly stated. The process to grant practicing privileges (flow chart), should identify those individuals responsible for each step in the process including the role of the MAC.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.1.	
Area for Improvement 3 **Ref:** Standard 11 Standard 19 **Stated:** First time	The responsible persons shall review/update practicing privileges agreements to ensure the following is formally recorded; Mandatory training and any other training requirements to work in the clinic are met and are up to date. The requirement for on-going registration with the ICO has been met.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.1.	

5.2 Inspection findings

5.2.1 Governance and Leadership

Organisational Governance

As previously stated, Hillsborough Private Clinic is part of the Affidea Group which also owns and operates Orthoderm Clinic and Affidea Belfast. The inspection team were informed that the Affidea Group had recently undertaken internal restructuring. Within the new organisational structure, the clinical manager has responsibility for the day to day management of Hillsborough Private Clinic and Orthoderm Clinic which is located close by and is supported by the HR and compliance manager. The clinic operations manager, Affidea Group, has overall responsibility for Orthoderm Clinic, Hillsborough Private Hospital and Affidea Belfast.

It was confirmed that Mr Gary McKee continues as the responsible individual and medical director. Inspectors were informed that a new registered manager application will be submitted to RQIA in respect of the clinical manager, in due course.

Various aspects of the organisational systems were discussed with Ms Weir. A range of minutes were reviewed which identified regular senior management team (SMT) governance meetings take place and evidenced information is disseminated to staff via team leads either face to face or via emails. It was evidenced that the SMT governance meetings are held bi-monthly and are attended by the medical directors, Ms Weir, the HR and compliance manager and departmental leads. Agenda items include clinical governance, quality, risk, compliance and audit. Meeting minutes detail the outcomes with time limited actions and the identified persons to address each action point and provide assurance to the responsible individual and medical directors. In addition, weekly operational meetings are attended by Ms Weir, the HR and compliance manager and the bookings and admissions lead.

Documents viewed during the inspection described a wide range of activities which included: monitoring of customer satisfaction; the outcomes of key performance indicators (KPI); audits; incident management and trend analysis. Audits were used to assess performance against agreed standards as part of a rolling audit programme. Audits included hand hygiene, environmental, infection prevention and control and the use of flexible scopes. Mechanisms were in place to ensure results from the audits were reviewed during the Medical Advisory Committee (MAC) meetings and shared with all staff.

Where the business entity operating a registered establishment is a corporate body or partnership or an individual owner who is not in day to day management of the service, unannounced quality monitoring visits by the registered provider, or person acting on their behalf, must be undertaken and documented every six months; as required by Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005. It was established that six monthly unannounced quality monitoring visits are undertaken by Mr McKee and the reports are shared with Ms Weir and presented at the MAC meeting and the bi-monthly SMT governance meetings.

Policies and procedures were available for staff reference with a system of review in place. Staff reported they were aware of the policies and how to access them.

A procedure for the dissemination and implementation of regional and national guidance, urgent communications, safety alerts and notices was in place to ensure all patient safety communications received were distributed and actioned appropriately in a timely manner.

The communication of information is also provided at staff meetings, by email, and also by information displayed on staff information boards.

Examination of insurance documentation confirmed that insurance policies were in place.

The RQIA certificate of registration was up to date and displayed appropriately.

It was also demonstrated that there were robust governance systems in place regarding the monitoring of medical, nursing and other health care professional bodies' registration status.

Clinical and medical governance

Clinical governance within Hillsborough Private Clinic was overseen by the MAC and directors meeting. 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). The chief executive officer of the Affidea Group also attends these meetings. 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. The outcome of completed audits, staff training compliance figures, the review of complaints/compliments and estates management matters were also included. These meetings were being undertaken on a quarterly basis in line with the criteria set out in Standard 30.

A team of consultant surgeons who have specialist qualifications and skills work in Hillsborough Private Clinic.

Hillsborough Private Clinic monitors individual consultant files, checking registration with the General Medical Council (GMC), professional indemnity and appraisals.

In accordance with the GMC all doctors must revalidate every five years. The revalidation process requires doctors to collect examples of their work to understand what they are doing well and how they can improve. As part of the revalidation process, responsible officers (RO) make revalidation recommendations to the GMC. Where concerns are raised regarding a doctor's practice information must be shared with their RO who then has a responsibility to share this information with all relevant stakeholders in the areas of the doctor's work. It was established that all medical practitioners working in the hospital have a designated RO. A discussion was held around how concerns would be raised regarding a doctor's practice with the MAC and within the wider Health and Social Care (HSC) sector. Hillsborough Private Clinic has established links with ROs of the doctors working in the organisation.

A small number of consultants are considered to be wholly private doctors as they are not affiliated with the HSC sector in Northern Ireland (NI) and are not on the General Practitioner's (GPs) performer list in NI.

Review of the 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

We reviewed the arrangements for the oversight and recording of induction and on-going training for consultants to ensure all consultants working in Hillsborough Private Clinic receive mandatory training and other training, supervision and appraisal in accordance with best practice guidance. A review of records demonstrated that the clinic retains a copy of each consultant's annual appraisal document. 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. Discussion with Ms Weir and the HR and compliance officer demonstrated that systems have been strengthened to ensure they have an accurate and up to date position on medical appraisal status which clearly evidences any delay. A tracking system was in place which recorded when appraisals have been received and if there has been a delay reason and the date the appraisal is expected to be submitted is documented. It was determined that the previous area for improvement 1, as outlined in section 5.1, had been met.

Whilst it is the responsibility of GMC registrants to keep up to date with their CPD activities, the CPD learning activities may not meet with legislative mandatory training such as fire safety, safeguarding adults, children and young people, infection prevention and control and resuscitation.

Discussion with Ms Weir and a review of records demonstrated that a staff training matrix was in place that included all staff and provided up to date information on staff training compliance. A review of the matrix evidenced a high rate of compliance in all areas of training and where training was due for renewal or had expired, these were highlighted for follow up. It was noted that in respect of consultant's training, compliance rates were not as high as other staff members. Ms Weir informed us that a fresh approach has been taken to ensure consultant's complete Hillsborough Private Clinic's mandatory training requirements and this begins at the point of a consultant making application to work in Hillsborough Private Clinic. The training matrix demonstrated that progress is being made in this regard. As previously discussed, training compliance rates are included in the quarterly MAC meetings.

A review of sample of staff personnel files confirmed that a record of induction and individual training records and certificates were retained to verify that training had been successfully completed.

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. Ms Weir informed us that that all medical practitioners who work in Hillsborough Private Clinic 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 had been updated and 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.

A review of the practising privileges agreement confirmed that there is clear and accurate information on when annual appraisals should be submitted and clear escalation actions are outlined if annual appraisals are not submitted within the specified time. This also includes the consequences should annual appraisals not be submitted, the timeframes and any assurances that may be sought to confirm the practitioner can continue to work in the clinic. It was determined that the previous area for improvement 2, as outlined in section 5.1, had been met.

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 ICO. It was determined that the previous area for improvement 3, as outlined in section 5.1, had been met.

A review of a sample of records evidenced that there was a written practicing privileges agreement between each private doctor and Hillsborough Private Clinic setting out the terms and conditions which had been signed by both parties. It was noted that the practising privileges agreements had been reviewed within the previous two years; clearly stated each consultant's scope of practice and had been signed by both parties.

As previously discussed, practising privileges matters are discussed and reviewed during the MAC meetings.

Discussion with the Hillsborough Private Clinic management team demonstrated that 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 by the organisation's quality and safety committee and at the 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 Hillsborough Private Clinic audit schedule. The results are monitored by the local and regional management team and actions identified for improvement are embedded into practice. If required, an action plan is developed to address any shortfalls identified during the audit process.

A system was also in place to ensure that urgent communications, safety alerts and notices are reviewed and where appropriate, made available to key staff in a timely manner.

Notifiable Events/Incidents

A policy for the management and reporting of clinical risks, incidents and near misses and a policy for the management of national safety alerts was in place.

The management team confirmed that any learning from incidents would be discussed with staff. There was a process in place for analysing incidents and events to detect potential or actual trends or weakness in a particular area in order that a prompt and effective response can be considered at the earliest opportunity.

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

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.

A review of the complaints log confirmed that all complaints received since the previous inspection had been investigated and responded to appropriately to include details of all communications with complainants; the result of any investigation; the outcome and any action taken. A complaints audit was available on the day of inspection for review. It was found to be up to date and capable of reflecting any themes emerging from complaints analysis with any action taken to address themes being recorded. Learning is disseminated across all staff groups to drive improvement in the quality of this service, which staff confirmed during the inspection. The management of complaints is reviewed on a weekly basis with an over-arching quarterly audit of complaints to identify trends or themes emerging. The quarterly audit of complaints is included as a standing agenda item for the MAC meetings.

Notifiable events/incidents

Systems are in place to support good risk management within the clinic. This ensures that the likelihood of adverse incidents, risks and complaints are minimised by effective identification, prioritisation, treatment and management.

Risks were documented, collated and tracked through the use of a risk register which provided assurance about the effective identification and management of risk.

Overall, the governance structures within the hospital provided the required level of assurance to the responsible individual and the Hillsborough Private Clinic.

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 largely in keeping with legislation and best practice guidance.

Advice was provided on this matter and an amended recruitment and selection policy was submitted to RQIA following the inspection which was found to be in keeping with legislation and best practice guidance.

A staff register was available to review and was found to be up to date and contained staff details in keeping with legislation.

It was evidenced that, staff were recruited and employed in accordance with relevant employment legislation and best practice guidance. Six staff personnel files were reviewed, inclusive of newly recruited staff, and evidenced that information required by legislation was obtained and retained in the files. An induction programme was available for newly recruited staff and was found to be robust and well completed.

A review of duty rotas and discussion with staff evidenced that there were sufficient staff in various roles to fulfil the needs of the clinic and patients.

A review of a sample of records and discussion with staff evidenced that supervision has been completed on a regular basis and appraisals had been completed on an annual basis. Staff reported that they were well supported and fully involved in discussions about their personal and professional development.

As previously discussed the training matrix reviewed evidenced that training was up to date. Induction programme templates were in place relevant to specific roles within the hospital. It was identified that some staff had not completed laser safety training within the last five years. The clinic should ensure that all staff receive laser safety awareness training appropriate to their role and up to date training records are maintained. Following the inspection RQIA received verification that all relevant staff had completed laser safety awareness training as advised.

Staff told us that there were good working relationships throughout the hospital and we found clear evidence of multidisciplinary working.

Ms Weir confirmed there is a system in place to review the registration details of all health and social care professionals with their professional bodies. Records were available for review in this regard.

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

5.2.3 Are there safe practices in place for the day surgery/endoscopy services?

The inspectors reviewed the arrangements for the provision of day surgery and endoscopy services in the hospital as outlined in the statement of purpose and categories of care. The review of day surgery and endoscopy arrangements evidenced that these services will operate in accordance with best practice and national standards to ensure care delivery is safe and effective.

It was confirmed that adult surgical services are provided. The scheduling of patients for surgical procedures is co-ordinated by the clinical co-ordinator, the consultant and the administration office. The theatre lists 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.

The patient will be 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. The consented patient is then escorted to the theatre room.

Staff confirmed that there will be an identified member of nursing staff, with relevant experience, in charge during all procedures. However, this was not formally recorded and it was advised to ensure the identified member of nursing staff in charge of the theatre is clearly outlined on the duty rota. Management gave assurances this matter would be addressed with immediate effect. Staff complete a surgical safety checklist based on World Health Organisation (WHO) guidance and completion of the surgical checklist and compliance was being routinely audited through the hospital's auditing process.

It was confirmed that patients are observed during and after the procedure by appropriately trained staff. Patients are discharged in accordance with 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. Patients are provided with clear, post procedure advice, information on follow up and who to contact in the event of a post treatment emergency.

A surgical register was in place and found to be well recorded in accordance with regulation. It was confirmed no surgical assistants were used in the hospital.

Supplies of sterile instrument packs and reprocessed endoscopes are obtained from an approved sterile services department under contract from a HSC Trust. 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.

Three completed day surgery patient care pathways and endoscopy patient care pathways were reviewed and were found to provide a framework for clear records of admission, medical history, infection prevention and control status, medication, observations on admission, pre-procedure checklist, the WHO surgical safety checklist, intra-procedure details, traceability details, post procedure observations and a discharge record.

There were procedures for the collection, labelling, storage, preservation, transport and administration of specimens. Staff clearly described detailed procedures for the management of specimens and the procedure for reporting results to the appropriate clinical staff and GP's. A pathology specimen procedure was in place which reflected best practice and there was a contract in place with a pathology laboratory service which is subject to internal audit.

An emergency trolley is located in theatre and checked daily by nursing staff. Emergency medicines, oxygen and equipment were all in date with the exception of paediatric automated external defibrillator pads which were order. It was noted that some equipment expiry dates were not recorded on the monitoring records and it was advised to include these dates to ensure clear stock control measures are in place. Management informed us that equipment expiry dates would be included with immediate effect.

Medical emergencies were discussed including the management of massive blood loss emergency. There was separate massive blood loss tray in place.

As outlined previously a paediatric surgery service is not provided however a paediatric outpatients service is provided. It was noted that paediatric emergency medicines and equipment are available within the emergency trolley. However, they are not separate from the adult emergency drugs and equipment. Advice was provided to establish a separate paediatric medical emergency grab bag/tray to allow ease of access to the paediatric emergency drugs and equipment in the event of a paediatric medical emergency. Management gave assurances to establish a separate paediatric medical emergency grab bag or tray with the involvement of appropriate medical staff.

It was determined that safe practices were in place for delivery of day surgery and endoscopy services.

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

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

The laser service is provided in the theatre suite. It was confirmed that laser eye procedures are only carried out by a consultant ophthalmologist acting as the clinical authorised operator assisted by nursing staff acting as non-clinical authorised operators.

A review of the laser safety files found that they contained all of the relevant information required with regards to the laser equipment in use. Following the inspection RQIA received confirmation that all relevant staff had signed to confirm that they had read the contents of the laser safety file.

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 clinic and the LPA had been reviewed and was in date.

The clinic's LPA had completed a risk assessment of the premises during 29 May 2024 and recommendations made were being addressed.

It was confirmed that laser eye surgical procedures are undertaken by the consultant ophthalmologist in accordance with medical treatment protocols produced by the consultant ophthalmologist. Systems were in place to review the medical treatment protocols on an annual basis. A register of clinical and non-clinical authorised operators for the lasers was maintained.

Up to date, local rules were in place which have been developed by the LPA and reviewed on 25 May 2024.

Review of the local rules confirmed that all the required information was included as follows:

- 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

It was confirmed that the Laser Protection Supervisor (LPS) is aware that when the laser equipment is in use, the safety of all persons in the controlled area is their responsibility. Arrangements were in place for an authorised operator to deputise for the LPS, when required, who is suitably skilled to fulfil the role.

It was confirmed that the laser surgical register is maintained every time the laser is operated to include:

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

A review of the laser surgical register found it to be comprehensively completed.

The theatre suite where the laser equipment is used was found to be safe and controlled to protect other persons while treatment is in progress.

The laser is operated using a key that unauthorised staff do not have access to and there were arrangements in place in relation to the safe custody of the key for the laser equipment.

Protective eyewear was available for laser assistants when required and for purposes of equipment maintenance. The laser safety warning signs are displayed and also illuminated outside of the laser suite when the laser is in use and the illuminated light is turned off when the laser is not in use, as described within the local rules.

Arrangements have been established for the laser equipment to be serviced and maintained in line with the manufacturer's guidance. The most recent service reports reviewed were dated 3 March 2024.

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

As stated previously the LPA for RQIA also reviewed the safe use of the laser equipment currently in use. Their findings and laser safety report are appended to this report.

It was determined that appropriate arrangements were in place to safely operate the laser equipment.

5.2.5 Estates

The following documentation was reviewed in relation to the maintenance of the premises including the mechanical and electrical installations:

- fire risk assessment
- service records for the premises fire alarm and detection system
- service records for the premises emergency lighting installation
- service records for the premises portable fire-fighting equipment
- records of fire drills undertaken
- Lifting Operations and Lifting Equipment Regulations (LOLER) 'Thorough Examination' reports of the premises' stair lifts
- condition report for the premises' fixed wiring installation
- report for the formal testing of the premises portable electrical appliances
- legionella risk assessment
- service records, validation checks and audits for the premises' critical ventilation systems

The premises general mechanical and electrical systems are currently being serviced and maintained in accordance with current regulations and best practice guidance.

The most recent legionella risk assessment was undertaken on 22 June 2022 and no significant actions were noted. Suitable control measures and temperature monitoring of the premises' hot and cold water systems was in place with records being maintained as recommended. Water samples analysed on 27 April 2024 did not detect any legionella or pseudomonas aeruginosa bacteria in the premises hot and cold water systems.

The current fire risk assessment was reviewed on 29 November 2023. The overall assessment was assessed as 'tolerable' and no significant findings were identified. The most recent fire drill for the premises was undertaken on the 29 March 2024. Any issues identified during this drill were immediately followed up by management and advice issued to staff.

The premises critical ventilation systems are serviced in accordance with current best practice guidance and suitable validation is undertaken in accordance with the current health technical memoranda. Records and validation reports were available and reviewed at the time of the inspection.

It was determined that procedures are in place for maintaining the premise, grounds, engineering services and equipment in line with legislation, current standards of best practice and manufacturer's and supplier's guidance and that these are regularly reviewed and updated.

6.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Weir, clinical manager; the HR and compliance manager and the clinic operations manager, Affidea Group, as part of the inspection process and can be found in the main body of the report.

Appendix 1

The Regulation and Quality Improvement Authority
James House
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28 June 2024

Laser Protection Report

Site Details:
Hillsborough Private Clinic
2 Main Street
Hillsborough
Co Down
BT26 6AE

Laser Protection Adviser appointed by site:

Anna Bass, Lasermet

Laser Equipment:

Make	Model	Class	Serial Number	Wavelength
Nidek	YC-1800	3B	Y1650186	1064nm

Introduction

A Laser Protection Adviser inspection of Hillsborough Private Clinic was performed on 6 June 2024. 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. **Training:** Records showed that some staff had not completed laser safety training within the last 5 years. The clinic should ensure that all staff receive laser safety training appropriate to their role and up to date training records are maintained. The clinic should also ensure that all relevant staff have read and signed the laser manual.

2. **Laser File:** There were multiple versions of some documents held in the laser file. Consideration should be given to placing older superseded versions of the documents in an archive section within the file, or alternatively these documents could marked in some way to make clear they are no longer in use.

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

Mrs Jane Brown
Laser Protection Adviser to RQIA

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