The Regulation and Quality Improvement Authority

Inspection Report

19 February 2025

Optimax Clinics Limited

Type of Service: Independent Hospital-Refractive Eye Lasers
Address: 7 Derryvolgie Avenue, Belfast, BT9 6FL
Telephone number: 028 9066 1118

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 the Minimum Care Standards for Independent Healthcare Establishments (July 2014)

1.0 Service information

Applicant Organisation/Provider: Optimax Clinics Limited **Responsible Individual:** Mr Russell Ambrose	**Registered Manager**: Mrs Fiona Quinn **Date registered:** 12 August 2019
Person in charge at the time of inspection: Mrs Fiona Quinn	
Categories of care: Independent Hospital (IH) PT(L) Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers PD Private Doctor	
Brief description of how the service operates: Optimax Clinics Limited is registered with the Regulation and Quality Improvement Authority (RQIA) as an Independent Hospital (IH) with the following categories of care: Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers PT(L) and private doctor (PD) categories of care. Optimax Clinics Limited (Optimax) is the registered provider for Optimax Clinics Limited - Belfast and Mr Russell Ambrose is the responsible individual. Optimax Clinics Limited - Belfast provides laser vision correction to persons over 18 years of age. Optimax has eighteen clinics located across the United Kingdom. In the instance that patients received lens surgery at another site managed by Optimax, the patient may attend Optimax Clinics Limited - Belfast for pre/post-operative care. **Equipment available in the service:** **Laser equipment:** Manufacturer: Schwind Model: Amaris Serial Number: S244 Laser Class: 4 Wavelength: 193 nm Manufacturer: IntraLase Model: FS60 Serial Number: S0506-40039 Laser Class: 3B Wavelength: 1053 nm	

Types of laser treatments provided:
Refractive eye surgery – Lasek, Lasik and Photorefractive Keratectomy

2.0 Inspection summary

This was an announced inspection, undertaken by three care inspectors on 19 February 2025 from 10.00 am to 4.00 pm. 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 purpose of the inspection was to assess progress with areas for improvement identified during and since the last inspection and assess compliance with the legislation and minimum standards.

There was evidence of good practice concerning staff recruitment; authorised operator training; safeguarding; laser safety; the management of the patients' care pathway; the management of medical emergencies; infection prevention and control (IPC); the management of clinical records; clinical and organisational governance; and effective communication between patients and staff.

Additional areas of good practice identified included 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.

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. This inspection was facilitated by Mrs Quinn, Registered Manager.

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.

Patients were not present on the day of the inspection and patient feedback was assessed by reviewing the most recent patient satisfaction surveys completed by Optimax Clinics Limited - Belfast.

Posters were issued to Optimax Clinics Limited - Belfast by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire.

No patient responses were submitted.

Three staff submitted questionnaire responses. Staff responses indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. All of the staff indicated that they were either satisfied or very satisfied with each of these areas of patient care. One staff member commented that staff felt valued and that the clinic is well managed.

5.0 The inspection

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

The last inspection to Optimax Clinics Limited - Belfast was undertaken on 15 February 2024; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 How does this service ensure that staffing levels are safe to meet the needs of patients and staff are appropriately trained to fulfil the duties of their role?

Staffing arrangements were reviewed and it was confirmed that there are appropriately skilled and qualified staff involved in the delivery of services. The staff team includes a consultant ophthalmologist, an optometrist, registered nurses and laser assistants. Mrs Quinn confirmed that these staff have specialist qualifications and are suitably skilled and experienced in refractive laser eye surgery patient care.

The clinic staff take part in ongoing training to update their knowledge and skills, relevant to their role. Induction programmes relevant to roles and responsibilities are required to be completed when new staff join the team. A review of documentation evidenced that a new staff member recently recruited had completed an induction programme.

A 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 records confirmed that all staff had undertaken training in keeping with RQIA training guidance.

Discussion with Mrs Quinn and review of documentation identified that arrangements were in place to check the registration status of all clinical staff on appointment and on an ongoing basis; to monitor staff professional indemnity and any practicing privileges agreements. These matters are discussed further in section 5.2.8.

Staff spoke positively regarding the clinic and their working relationships, they felt valued as members of the team and supported by management.

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

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

The arrangements in respect of the recruitment and selection of staff were reviewed.

A recruitment policy and procedure was in place which was comprehensive and reflected best practice guidance. Optimax has a corporate human resources (HR) shared services department. The corporate HR department supports the registered manager during the recruitment process. The HR department is responsible for developing job descriptions, induction templates and employment contracts bespoke to roles and responsibilities; and issuing reference requests. The registered manager is responsible for ensuring all recruitment records have been sought and uploaded to the electronic HR system. Discussions confirmed Mrs Quinn had a clear understanding of recruitment and selection legislation and best practice guidance.

The staff register reviewed was found to include the names and details of staff in keeping with legislation. It was noted that one new staff member had been appointed since the previous RQIA inspection. A review of the new staff member's personnel file evidenced that not all recruitment documentation, as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005, had been sought and retained for inspection. This area was discussed with Mrs Quinn and assurances were given that this matter would be addressed.

As a result of assurances given, it was determined that recruitment and selection procedures were in place to ensure compliance with the legislation and best practice guidance.

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

Mrs Quinn confirmed that treatments are not provided to persons under the age of 18 years.

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

Review of records demonstrated that all staff had received training in safeguarding adults as outlined in the Minimum Care Standards for Independent Healthcare Establishments July 2014.

Mrs Quinn confirmed that staff were aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified. The safeguarding champion named in the clinic policy had completed safeguarding training at the level required in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016) and minimum standards.
It was confirmed that a copy of the regional guidance document entitled Adult Safeguarding Prevention and Protection in Partnership (July 2015) was available for reference.

Appropriate arrangements were in place to manage a safeguarding issue should it arise.

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

The arrangements in respect of the management of medical emergencies were reviewed.

Review of the medicines management policy found that it accurately reflected the arrangements in place to manage a medical emergency.

Protocols were also available to guide the team on how to manage recognised medical emergencies. The British National Formulary (BNF) and the Resuscitation Council (UK) specify the emergency medicines and medical emergency equipment that must be available to safely and effectively manage a medical emergency.

Review of the emergency trolley found that systems were in place to ensure that emergency medicines and equipment do not exceed their expiry date and are immediately available. Staff spoken with 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.

A review of training records and discussion with staff confirmed that the management of medical emergencies is included in the induction programme and training is updated on an annual basis in keeping with best practice guidance.

Review of the arrangements to manage a medical emergency identified that staff were suitably trained and appropriate medicines and equipment were in place to manage a medical emergency should one arise.

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

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

There were IPC policies and procedures in place that were in keeping with best practice guidance. A tour of the premises was undertaken and the clinic was found to be clean, tidy and uncluttered.

Cleaning schedules were in place and cleaning records were completed and up to date. Mrs Quinn discussed the procedure to decontaminate the environment and equipment between patients and this was in keeping with best practice.

A review of training records confirmed that staff had received IPC training commensurate with their roles and responsibilities.

Staff spoken with on inspection demonstrated good knowledge and understanding of IPC procedures. Personal protective equipment (PPE) was readily available in keeping with best practice guidance and according to the treatments provided.

The laser suite provided dedicated hand washing facilities and hand sanitiser was available throughout the clinic. Mrs Quinn and the IPC lead nurse confirmed only single use equipment is used for refractive laser treatments.

There are contracts in place for disposal of sharps, clinical waste and pharmaceutical waste.

It was evidenced that a robust programme of IPC auditing is in place including an unannounced audit by the IPC expert advisor for Optimax.

Audit compliance rates were found to be high. Mrs Quinn confirmed audit results are shared across all Optimax clinics for learning and development purposes. The findings from incidents relating to IPC matters are also shared and learning is disseminated across all Optimax Clinics. Mrs Quinn told us that regular inter-clinic IPC meetings take place.

The service had appropriate arrangements in place in relation to IPC and decontamination.

5.2.6 How does the clinic ensure laser procedures are safe?

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

The service has one laser suite and a number of consultation and treatment rooms. It was confirmed that refractive laser eye procedures are only carried out by a consultant ophthalmologist as the clinical authorised operator, supported by laser assistants acting as non-clinical authorised operators. A register of clinical and non-clinical authorised operators for the lasers is maintained and kept up to date.

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. 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 March 2024; no recommendations were made.

Mrs Quinn confirmed that laser eye surgical procedures are undertaken by the consultant ophthalmologist in accordance with medical treatment protocols produced by the medical directors of Optimax. Systems were in place to review the medical treatment protocols on an annual basis.

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.

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

Mrs Quinn confirmed that the LPS is aware that when the laser equipment is in use, the safety of all persons in the controlled area is their responsibility.

As previously discussed, a review of training records confirmed that all clinical and non-clinical authorised 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. Review of documentation and discussion with Mrs Quinn confirmed that clinical authorised operators had undertaken application training for the equipment in use.

Mrs Quinn confirmed that the laser surgical register is maintained every time the lasers are 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 laser suite where the laser equipment is used was found to be safe with access controlled to protect other persons while treatment is in progress.

Mrs Quinn confirmed that both sets of doors to the laser suite are locked when the laser equipment is in use and can be opened from the outside in the event of an emergency.

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

Protective eyewear is 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 manufacturers' guidance.

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

The fire risk assessment had been reviewed during December 2024. Servicing of firefighting equipment was undertaken during February 2025.

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

5.2.7 How does the clinic ensure patients have a planned programme of care and have sufficient information to consent to treatment?

Staff confirmed that all patients have a clinical evaluation with an optometrist who provides information and discusses treatment options.

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

The clinic has a list of fees available for each type of surgical procedure. Fees for treatments are agreed during the initial consultation and may vary depending on the individual patient's prescription and surgery options available to them.

In accordance with General Medical Council (GMC) and the Royal College of Ophthalmologists guidance, patients have a consultation 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 for purposes of medical review and 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. Systems were in place to refer patients directly to the consultant ophthalmologist or optometrist if necessary.

Staff informed us that systems were in place to review the patient following surgery at regular intervals if necessary.

Two patient care records reviewed were found to be well documented, contemporaneous and clearly outlined the patient journey. The clinic has recently introduced an electronic care record (ECR) and consent procedure.

The management of paper and electronic records within the clinic was found to be in line with legislation and best practice.

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.

5.2.8 Are robust arrangements in place regarding clinical and organisational

Organisational governance

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

Mr Russell Ambrose is the owner and a director of Optimax Clinics Limited. He is the responsible individual with RQIA for Optimax Clinics Limited - Belfast. Mrs Quinn is the registered manager, who is in day to day charge of the clinic, and is supported in this role by the head of commercial operations, Optimax.

Where the business entity operating a refractive eye service 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.

The most recent unannounced monitoring visit was undertaken on 11 February 2025 by the head of compliance, Optimax. A report of the visit was produced and made available to Mrs Quinn any other interested parties to read. An action plan had been developed to address any issues identified during the visit which included timescales and the person responsible for completing the action.

Arrangements should be in place to provide copies of these reports to the responsible individual to enable them to monitor progress with the identified actions. However, it could not be evidenced that Mr Ambrose had reviewed the most recent monitoring reports. Advice was provided to Mrs Quinn to ensure that reports of these unannounced monitoring visits along with any identified actions are forwarded to Mr Ambrose for review and sign off. Mrs Quinn provided assurance that this matter would be addressed.

It was noted that the last monitoring visit had been conducted by an Optimax compliance manager during March 2024. In addition, a compliance visit was undertaken by an IPC nurse six months later (September 2024) to ensure infection prevention and control procedures were being followed. Advice and guidance was provided to Mrs Quinn regarding the legislative requirement for the registered provider to undertake an unannounced monitoring visit of the establishment at least once every six months. Mrs Quinn agreed to address this matter as priority with the compliance team.

Optimax Laser Eye Clinic - Belfast has a Medical Advisory Board (MAB) that includes Mr Ambrose along with the chief executive officer, the medical director, senior medical staff and directors of the organisation. A review of minutes confirmed that the MAB meets every three months. This meeting is also attended by the operations manager at Optimax who provides Mrs Quinn with an update of any developments at corporate level.

The MAB focuses on issues related to clinical practice such as doctors' performance, clinical outcomes audit, treatment pathways, potential new treatments, medical safety alerts, incidents and regulatory matters. The MAB also reviews doctors practising privileges and any new clinician appointments.

A medical board meeting also takes place each month that reports to the MAB and a medical society for clinicians at which nurses also meet. Compliance managers hold monthly compliance team meetings remotely, to which Mrs Quinn attends with fellow clinic managers across the UK on a monthly basis.

Staff spoken to on the day stated that there were good working relationships within the team and that management was responsive to any suggestions or concerns raised by staff. Staff confirmed that they had an effective forum to share their opinions on the service.

Clinical governance

As discussed the clinical team includes a consultant ophthalmologist, an optometrist, a registered nurse and laser technicians/surgical assistants who have evidence of specialist qualifications and skills in refractive laser eye surgery.

The consultant ophthalmologist is considered to be a wholly private doctor as they are not affiliated with the Health and Social Care (HSC) sector in Northern Ireland (NI) and are not on the General Practitioner's (GP's) performer list in NI.

Review of the consultant ophthalmologist's 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 GMC
- ongoing annual appraisal by a trained Medical Appraiser
- an appointed responsible officer (RO)
- arrangements for revalidation

As previously discussed the consultant ophthalmologist, who is a clinical authorised operator, has completed training in accordance with RQIA's training and is aware of their responsibilities under GMC Good Medical Practice.

All medical practitioners working within the clinic must have a designated RO. 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. Experienced senior doctors (called RO's) work with the GMC to make sure doctors are reviewing their work. As part of the revalidation process RO's make a revalidation recommendation 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 all areas of the doctor's work.

The consultant ophthalmologist working within the clinic has a designated external RO due to their prescribed connection with other health care organisations.

Practising Privileges

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

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 policy and procedural guidance for the granting, review and withdrawal of practicing privileges agreements was in place.

A review of the practising privileges record for the consultant ophthalmologist confirmed that all required documents were in place and had been signed by both parties. The agreement defined the clinician's scope of practice. It was confirmed that the private doctor's practising privileges agreement is reviewed by the MAB and updated every two years.

A review of the oversight arrangements of the granting of practicing privileges agreements has 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.

The service scheduled regular audits throughout the year and these are undertaken by the clinic manager and staff. The audit programme includes health and safety and general patients' safety-related audits related to the environment, infection control, and clinical record keeping amongst others. Results are used to benchmark the clinic against other services managed by the provider.

Patient satisfaction ratings are reviewed monthly by the clinic, and quarterly and annually by the Optimax compliance team. An annual report is produced for each Optimax clinic. The most recent report indicated that outcomes for patients were consistently positive and met their expectations however, advice and guidance was provided to Mrs Quinn to ensure that this information is subsequently made available to patients and other interested parties. Mrs Quinn agreed to find a resolution to this matter at the next team meeting.

We discussed with Mrs Quinn how the results of audits are analysed and how any identified shortcomings had been used to facilitate service improvements. A review of a sample of audit action plans demonstrated that actions that were to be taken in response to audit had been recorded, delegated to relevant staff and progress tracked.

Completed audits and any resulting actions are shared by Mrs Quinn at the Optimax monthly compliance meeting and in turn by the operations director at the senior compliance meeting.

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.

A statement of purpose and patient's guide were in place and Mrs Quinn confirmed that these documents will be kept under review when and updated as necessary.

The RQIA certificate of registration was up to date and displayed appropriately and current insurance policies were in place.

Notifiable Events/Incidents

An incident management policy and procedure was in place. A review of this policy confirmed that it included the reporting arrangements to RQIA and other relevant organisations in accordance with legislation and the RQIA Statutory Notification of Incidents and Deaths.

Discussion with Mrs Quinn and staff present confirmed that they recognised incidents and near misses and knew how to report them in line with the provider's policy.

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.

It was confirmed that Mrs Quinn would lead investigation into incidents and near misses and a monthly audit is undertaken. Any learning is shared and discussed with the clinic team locally and managers at the monthly compliance team meetings.

Complaints Management

Review of the complaints policy and procedure confirmed that it was in accordance with the Department of Health (DoH) guidance on complaints handling Health and Social Care Complaints Procedure (Revised April 2023) and The Independent Health Care Regulations (Northern Ireland) 2005.

Staff told us that a copy of the complaints procedure is made available to patients/and or their representatives on request. Complaint forms are held at reception. Staff spoken to understood the policy on complaints and knew how to acknowledge any verbal or written complaints received.

Mrs Quinn confirmed that 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. Mrs Quinn, as the clinic's complaints manager, demonstrated how she records and tracks progress of all complaints locally using a spreadsheet.

Optimax has a customer services and complaints handling department in London where all complaints received are handled and any themes identified. Complaints are discussed during management meetings. Actions that could be taken to minimise the likelihood of complaints between services and to improve quality of services are identified. Mrs Quinn confirmed that she shares lessons learned with all staff.

Overall, the governance structures within the clinic provided the required level of assurance to the senior compliance team and the MAB.

5.3 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 staff. Discussion and review of information evidenced that the equality data collected was managed in line with best practice.

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 Mrs Quinn, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Appendix

Belfast Health and Social Care Trust
caring supporting improving together

Site Details:
Optimax Clinics Ltd
7 Derryvolgie Avenue
Belfast
BT9 6FL

Laser/IPL Equipment:

Make	Model	Class	Serial Number	Wavelength(s)
Schwind	Amaris	4	S244	193 nm (ArF)
Intralase	FS	3B	0506-40039	1053 nm (Nd:Glass)

Introduction

An inspection of Optimax was performed on 19 February 2025. 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:

No comments or recommendations are necessary.

Signed by LPA to RQIA on 21 February 2025

The Regulation and Quality Improvement Authority

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