Inspection Report

12 June 2025

Hillsborough Private Clinic

Type of service: Independent Hospital – Surgical Services
Address: Cromlyn House, 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 Establishments

1.0 Service information

Organisation/Registered Provider: Cromlyn House Surgical Ltd **Responsible Individual:** Mr Gary McKee	**Registered Manager:** Mrs Thelma Turner **Date registered:** 3 January 2025
Person in charge at the time of inspection: Mrs Thelma Turner	
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**: Ten 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 12 June 2025 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 12 June 2025 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.

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

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).

The inspection team undertook a tour of the premises and the inspection was facilitated by Mrs Turner.

During the inspection we spoke with Mrs Turner, registered manager and clinical manager; the human resources (HR) and compliance manager; a senior nurse and several theatre nurses.

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?

The last inspection to Hillsborough Private Clinic was undertaken on 6 June 2024; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Governance and Leadership

Organisational Governance

Hillsborough Private Clinic is part of the Affidea Group which also owns and operates Orthoderm Clinic and Affidea Belfast. 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 Hillsborough Private Hospital, Orthoderm Clinic and Affidea Belfast.

It was confirmed that Mr Gary McKee continues as the responsible individual and medical director.

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 and 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 Mrs Turner and presented at the MAC meeting and the two monthly SMT governance meetings.

Policies and procedures were available for staff reference and discussion with Mrs Turner confirmed that a structure is in place to ensure that policies are being reviewed in a systematic manner. Staff reported they were aware of the policies and how to access them.

The Competition and Markets Authority (CMA) requires all hospitals and consultants offering private treatment to submit data to Private Healthcare Information Network (PHIN) as the Information Organisation for private healthcare. This provides people considering private healthcare with clear information to help them to make an informed choice of which consultant and hospital is right for them. A review of the PHIN website confirmed that Hillsborough Private Clinic is registered with this organisation. It was confirmed that any consultant providing private healthcare in Hillsborough Private Clinic is required to register with PHIN and submit information to PHIN as outlined by the organisation.

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.

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.

Staff who spoke with us were able to describe their roles and responsibilities and confirmed that there were good working relationships with managers, who were responsive to any suggestions or concerns raised.

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

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

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 also estate management matters. 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, professional indemnity and appraisals. Registration status is verified with the General Medical Council (GMC).

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's) 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 doctors working in the clinic 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 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 (2024) guidance.

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 staff 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 consultant's training compliance rates had improved since the last inspection and the training matrix demonstrated that progress had been 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. Mrs Turner informed us that that all medical practitioners working in Hillsborough Private Clinic have a practising privileges agreement in place.

It was noted the Hillsborough Private Clinic website provides information on consultants' eligibility for the granting of practising privileges in Hillsborough Private Clinic.

A detailed policy and procedural guidance for the granting, review and withdrawal of practicing privileges agreements was in place. This procedure includes the practicing privileges applicant having an interview/meeting with one of the medical directors and/or the clinical manager.

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. It was noted that the practising privileges application also includes a requirement to demonstrate completion of specific areas of mandatory training.

A review of a sample of private doctor records evidenced that there was a written practicing privileges agreement between the private doctor and Hillsborough Private Clinic setting out the terms and conditions which had been signed by both parties.

It was evidenced that these 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 procedures. 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 were in place.

Hillsborough Private Clinic 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 actual or potential 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 bi-monthly SMT governance meetings and quarterly MAC meetings.

Complaints Management

A copy of the complaints procedure was available in the hospital 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 audit 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. It was confirmed that any learning coming out of a complaint 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 undertaken to identify trends or themes emerging at an early stage. The quarterly audit of complaints is included as standing agenda item for the MAC meetings.

Risk Management

Systems were in place to support good risk management within the hospital. 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 Affidea Group.

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

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

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 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.

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

Mrs Turner 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 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 patient records relating to day surgery care pathways and endoscopy 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.

Medical emergencies were discussed including the management of a massive blood loss. There was a 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 in the out patients' department. Advice and guidance was provided to the lead outpatients nurse to establish a separate paediatric medical emergency grab bag or tray to allow ease of access to the paediatric emergency drugs and equipment in the event of a paediatric medical emergency. Management gave assurances that a separate paediatric medical emergency grab bag or tray would be established, with the involvement of appropriate medical staff, and following the inspection, RQIA received photographic evidence that this matter had been addressed.

As a result of the actions taken following the inspection, it is determined that safe practices are 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.

Applications training for three authorised operators were not available for review. Following the inspection RQIA received confirmation that all authorised operators had received applications training and that records of training were in place.

A review of the laser safety files found that they did not contain all of the relevant information required with regards to the laser equipment in use. Following the inspection RQIA received confirmation that the laser files and treatment room files had been updated as advised and that all relevant staff had signed to confirm that they had read the contents of the laser safety file. Ms Turner confirmed the files would be reviewed on a regular basis to ensure they are up to date and complete.

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 undertaken a site audit of the premises on 4 June 2025, however recommendations made had not been signed to verify these areas had been actioned.

This was discussed with Mrs Turner and following the inspection RQIA received confirmation that the action list had been signed to record the actions had been completed.

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

Up to date, local rules were in place which have been developed by the LPA.

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 noted that the local rules stated the protection level for the eyewear however details of the wavelength required was not included. This was discussed and following the inspection RQIA received a copy of an updated set of local rules that stated the wavelength as advised.

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 that whilst most records were correctly completed, some records had not been fully completed. This was discussed with Mrs Turner who provided assurance that authorised operators would be reminded to complete all fields in the laser register. Mrs Turner confirmed that a system would be developed to audit this.

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 9 May 2025.

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.

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 Turner, Registered Manager and the HR and Compliance manager, as part of the inspection process and can be found in the main body of the report.

Appendix 1

08 July 2025

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 12 June 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:

1. **Training Records:** There were no records of applications training for three of the authorised users. The clinic should ensure that all authorised users have received applications training and records of the training are maintained. The clinic should also ensure that all Authorised Users have read and signed the laser manual.

2. Site Audit Report Action List: Although the actions appeared to be completed, the action list had not been signed to record this. The clinic should ensure that actions on action lists are signed once completed.

3. Local Rules:

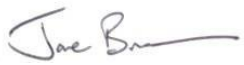
- The protection level for the eyewear is stated on page 2 of the local rules, however details of the wavelength required was not included. This is most likely a typographical error and the clinic should ask the LPA to update this.
- When a new version of the local rules is issued, the clinic should ensure that laser staff read and sign the new version.

4. Treatment Register: Whilst most records were correctly filled in, some records were not fully complete. The clinic should remind users of the importance of completing all fields in the laser register and put in place a system to audit this.

5. Laser Safety File & Treatment Room Files: Both files should be reviewed on a regular basis to ensure that they are up-to-date and records appropriately filed. During the inspection visit, the following issues were identified and should be addressed by the clinic:

- Treatment Protocols: There were different versions of the laser treatment protocols in the Laser Safety File (June 22 Version) and the Treatment Room File (August 23 version).
- LPA Support Certificate: The current LPA Support Certificate was not in the laser safety file.
- Local Rules: Although the current version of local rules were in the laser safety file, the version in the treatment room file had been superseded.

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



Mrs Jane Brown
Laser Protection Adviser to RQIA

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