The Regulation and Quality Improvement Authority

Inspection Report

20 and 21 November 2024

Ulster Independent Clinic

Type of service: Independent Hospital – Surgical Services
Address: 245 Stranmillis Road, Belfast, BT9 5JH
Telephone: 028 9066 1212

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: Ulster Independent Clinic Limited **Responsible Individual:** Ms Diane Graham	**Registered Manager:** Ms Diane Graham **Date registered:** 11 April 2007
Person in charge at the time of inspection: Ms Diane Graham	**Number of registered places:** Seventy
Categories of care: Acute Hospital (with overnight beds) - AH Acute Hospital (day surgery) - AH (DS) Private Doctor - PD Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers - PT (L) Prescribed techniques or prescribed technology: establishments using endoscopy - PT (E)	
Brief description of the accommodation/how the service operates: The Ulster Independent Clinic (UIC) provides a wide range of surgical, medical and outpatient services for both adults and children. The hospital is registered to accommodate up to 70 patients as in-patients or day surgery cases. The hospital has eight theatres along with recovery units; a dedicated endoscopy suite; a one stop breast care clinic; a limited chemotherapy service; an x-ray department and magnetic resonance imaging (MRI) scanning; a urology surgical laser service; a pathology laboratory; and a range of consulting rooms. The in-patient and day surgery accommodation comprises of single en-suite rooms which are situated over two floors. The hospital also operates a Hospital Decontamination and Sterilisation Unit (HDSU) used to decontaminate equipment for use within the hospital.	

2.0 Inspection summary

A short notice announced inspection was undertaken to the Ulster Independent Clinic (UIC) on 20 and 21 November 2024 and included a request for the submission of information electronically.

The onsite care component of the inspection was undertaken by a senior inspector, four care inspectors and an ADEPT (Achieve Develop Explore Programme for Trainees) Fellow on the 20 and 21 November 2024.

The ADEPT fellowship provides senior doctors in training with an opportunity to take time off their medical training for one year and work in an apprenticeship model with senior leaders in host organisations across Northern Ireland in order to develop organisation and leadership skills

RQIA's estates inspector completed an onsite inspection of the premises on 23 November 2024.

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.

Feedback of the inspection findings was delivered to the UIC management upon conclusion of 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).

The inspection team undertook a tour of the premises and the inspection was facilitated by Ms Graham and other staff members

The inspection team spoke with; Ms Graham; the quality and education team; the theatre manager; the senior theatre sister; theatre nursing staff; pathology staff; the residential medical officer; the inpatient unit ward sister, two inpatient unit deputy sisters; and members of the hospital liaison team.

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

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

4.0 What people told us about the service

Posters were issued to UIC by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire. No completed staff or patient questionnaires were received.

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 17 April 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 13 Criteria 13.9 **Stated:** First time	The registered manager must ensure: • All staff including medics, specialist nursing and AHPs have a recorded annual appraisal to review their performance against their job description, agree personal development plans and maintain evidence of CPD relevant to their role.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.4.	
Area for improvement 2 **Ref:** Standard 48 Criteria 48.2 Criteria 48.13 Criteria 48.17 Criteria 48.21	With respect to the use of lasers the registered manager must ensure: • A register of authorised users is maintained and kept up to date; • All support staff have up to date awareness training in laser and intense light source safety;	**Met**

Stated: First time **To be completed by:** 1 July 2023	• Protective eyewear is available for the patient and authorised operator in accordance with the local rules; and • A laser safety file is in place which contains all of the relevant information in relation to laser or intense light equipment.	
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.4.	
Areas for improvement from the last inspection on 1 May 2024		
Area for improvement 1 **Ref: Standard 21.8** **Stated: First time**	The responsible individual must fully implement the Department of Health (DoH) Authorised Engineer's requirements, as outlined in section 5.2.4 of this report.	**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 21.8** **Stated: First time** **To be completed by:** **1 August 2024**	The responsible individual shall ensure there is a suitable temporary area to be used by staff to don and doff personal protective equipment (PPE) until such times as a staff gowning area has been developed.	**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 21.9** **Stated: First time**	The responsible individual must ensure that all decontamination equipment installed in the HDSU is validated following installation.	**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
There was a clear organisational structure within the UIC and staff were able to describe their roles and responsibilities. Staff confirmed that there were good working relationships with managers who were responsive to suggestions or concerns raised. Staff said they would feel comfortable raising any concerns. Staff also informed us that they were respected and valued and confirmed that they felt well supported by the manager and the senior management team.

There were systems in place to promote effective communication with all staff. There was evidence of daily staff briefs, staff meetings and information was disseminated to staff directly from managers and through learning boards. Staff confirmed they received feedback and learning via staff meetings, emails, minutes, managers, and via the Governance Matters News Letter which is issued every two months.

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

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

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

UIC has a Clinical and Quality Governance Strategy in place which outlines the strategic direction for the hospital. A review of the quality improvement and clinical governance implementation plan outlined meeting schedules which purpose is to provide a flow of information both vertically and horizontally across the hospital. There was evidence of regular meetings taking place that included the Clinical Governance Committee (CGC), Medical Advisory Committee (MAC), and Practice Development Group. The minutes of these meetings were available for review.

A monthly governance report is compiled by the quality and education team and presented to the CGC meeting each month. These reports include information on staffing and staff management, medical staff practising privileges status, professional registration status for all staff, mandatory training, staff absence, hospital risk register, audits, clinical incidents and complaints and patient experience. Action plans were created to address any deficits in performance.

Risk management procedures were reviewed which provided assurance that risks identified with the hospital, treatment and services provided are identified, assessed and managed appropriately.

Systems were in place to ensure that the quality of services provided by the UIC is evaluated on an ongoing basis. Regular audits undertaken included; audits of venous thromboembolism (VTE) risk assessments, (the risk assessment is a tool used to assess a patients' risk of developing a blockage of a vein by a blood clot), infection prevention and control (IPC), surgical safety checklists, fluid balance charts, and prescription charts. A clear system was in place that addressed areas of non-compliance. The outcome of all audits undertaken are included in the Governance Matter News Letter.

Clinical and medical governance

Over 300 consultant specialists work in the hospital. The UIC's Board of Directors (the Board) requires consultant medical practitioners to practice in accordance with the General Medical Council (GMC) guidance 'Good Medical Practice', completing appropriate appraisal and revalidation requirements and adhering to the UIC's practising privileges conditions of membership.

The CGC meet on a monthly basis, with the function of assisting the Board in its oversight and integrity of UIC's clinical governance arrangements, including responsibilities regarding RQIA, the PHIN and Caspe Healthcare Knowledge Systems (CHKS). The duties of the CGC include; ensuring there is a robust mechanism for reporting and recording of all clinical incidents and to regularly review all such incidents; consider issues of concern relating to the clinical practice of an individual where identified and bring to the attention of the MAC; review and monitor all complaints relating to clinical issues; to have oversight and monitor the risk management system and controls in place and escalate any major risks identified to the Board; to ensure the MAC is in receipt of all consultants practising privileges documentation; to have oversight of the duties and responsibilities of the Resident Medical Officers and monitor their performance on a regular basis. In conjunction with the MAC, the CGC will identify areas appropriate for medical audit and will oversee these audits and outcomes.

The MAC meet quarterly with responsibility for surgeon performance and surgery specific matters. As discussed the CGC ensures all the documentation for consultants with practising privileges are in place including checking registration with the GMC, professional indemnity and appraisals. Terms of reference for the MAC were in place and these have been developed in accordance with Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments (2014). Ms Graham as the chief executive officer of UIC 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. A review of MAC meeting minutes confirmed that these meetings were being undertaken on a quarterly basis in line with the criteria set out in Standard 30.

The MAC also issue the 'MAC News' to consultants with information regarding maintenance of practising privileges and annual appraisal documentation, clinical audit outcomes, policy and procedure updates, theatre management arrangements and a summary of the most recent medical and drug safety alerts issued. Consultants are also reminded that any change to their scope of practice or an investigation into any aspect of their practice or any other institution (HSC or Independent Sector) must be immediately communicated to the chair of the governance committee and Ms Graham.

In accordance with the requirements of registration with the GMC, all doctors must revalidate every five years. The revalidation process requires doctors to collect examples of their work to understand what they are doing well and how they can improve.
Experienced senior doctors work as Responsible Officers (ROs) with the GMC to make sure doctors are reviewing their work. As part of the revalidation process, ROs make a revalidation

recommendation to the GMC. It was established that UIC is registered with the GMC as a designated body and have an appointed RO.

A number of consultants are considered to be wholly private doctors as they are not affiliated with the Health and Social Care (HSC) sector in Northern Ireland (NI) and are not on the Northern Ireland Primary Medical Performers List (PMPL). A review of sample of three consultant'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 the GMC
- ongoing annual appraisal by a trained Medical Appraiser
- an appointed RO
- arrangements for revalidation

Ms Graham outlined the clinical governance over-sight arrangements in place for UIC. It was established that all consultants who work in UIC are not directly employed and work under a practising privileges agreement.

We reviewed the arrangements for the oversight and recording of induction and on-going training for consultants to ensure all consultants working in UIC receive mandatory training and other training, supervision and appraisal in accordance with best practice guidance. It was confirmed that records of induction or records to evidence ongoing training provided by UIC were in place for staff who are not directly employed by UIC.

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. It was 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.

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 Graham informed us that that all medical practitioners (consultants) who work in UIC work under a practising privileges agreement.

A detailed policy and procedural guidance for the granting, review and withdrawal of practicing privileges agreements was in place. It was evidenced that this policy states that practising privileges can only be granted or renewed when full and satisfactory information has been sought and retained in respect of each of the records specified in Regulation 19 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended.

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 also demonstrated that the practising privileges application now includes a requirement to demonstrate completion of specific areas of mandatory training and also ongoing registration with the Information Commissioner's Office (ICO).

An electronic system is in place which clearly shows the status of all practising privileges agreements; this is colour coded to identify those agreements that had been reviewed within the previous two years; those that are due for renewal with a reminder issued to the consultant and those that are temporarily suspended due to information not being provided by the consultant. A review of a sample of records evidenced that there was a written practicing privileges agreement between each consultant and the UIC setting out the terms and conditions and the 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 Ms Graham 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 CGC 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 UIC audit schedule. As previously discussed the outcomes are monitored by the CGC and quality and education 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.

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

Notifiable Events/Incidents
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. This outlined the roles and responsibilities for the management of all notifiable events.

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 are investigated and responded to and included details of all communications with complainants; the result of any investigation; the outcome and any action taken. It was noted that a small number of complaints are long standing and have not yet reached a conclusion. It was also noted that one complainant had not received regular written updates in accordance with the UIC complaints procedure. This was discussed with Ms Graham, nominated complaints manager, who advised this omission had not been intended and was an oversight. Given Ms Graham's position as Chief Executive of UIC and also responsible individual and registered manager, it was suggested that consideration should be given to delegation of complaints management to a member of the senior management team with dedicated time provided to undertake the role of complaints management. Ms Graham was receptive to this advice.

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 an ongoing basis by the CGC 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.

Overall, the governance structures within the hospital provided the required level of assurance to the UIC board.

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 in the main, to be up to date. Advice and guidance was provided to Ms Graham to further develop the staff register to include all the required information in keeping with legislation and assurances were given that this matter would be addressed.

It was evidenced that staff were recruited and employed in accordance with relevant employment legislation and best practice guidance. Four 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 with the exception of one staff member. Advice and guidance was provided to Ms Graham and following the inspection RQIA received confirmation that this matter had been addressed,

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 had 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.

A review of the training matrix evidenced that training was up to date which was overseen by the quality and education team. 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 Graham 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.

As a result of the actions taken following the inspection, it is determined that appropriate staffing levels are 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.

There are eight theatres, four of which have laminar airflow ventilation. Robotic assisted surgery takes place for gynaecological procedures only in theatre four. There are three post-operative recovery areas adjacent to the theatre suites.

It was confirmed that adult and limited paediatric surgical services are provided. The scheduling of patients for surgical procedures is co-ordinated by the administration office, senior management and the theatre manager. 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.

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

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

A surgical register for each theatre was in place and they were found to be well recorded in accordance with regulation. It was confirmed surgical assistants are used in the hospital and a log is maintained of their participation in surgery. The surgical assistants have practising privileges with the hospital and operate within a defined scope of practice. This is further discussed in section 5.2.1 of this report.

UIC has an EN ISO 13485 certified Hospital Sterilisation and Decontamination Unit (HSDU) on site. The HSDU supplies sterile instrument packs and reprocessed endoscopes for surgical and endoscopy procedures. There are robust measures in place to monitor the traceability of all surgical instruments used in the hospital. Clinical equipment was evidenced to be clean and fit for purpose, and traceability labels were used to identify when equipment had been cleaned.

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

There is an accredited pathology laboratory on site which is subject to internal audit. Most pathology services are provided on site, however if further pathology investigations are required there is a contract in place for additional external pathology services. The pathology pathway was well described by senior pathology staff. There were procedures for the collection, labelling, storage, preservation, transport and administration of specimens. the procedure for reporting results to the appropriate clinical staff and GP's.

Emergency trollies are located adjacent to theatres and checked daily by nursing staff. Emergency medicines, oxygen and equipment were all in date. There were separate adult and paediatric emergency medicines and equipment in place.

Medical emergencies were discussed including the management of a massive blood loss emergency. Theatre management confirmed massive blood loss drills have taken place and that an update is to be arranged in the near future. There was a separate massive blood loss tray and relevant documentation folder in place.

Theatre management confirmed that joint replacement information is provided for the National Joint Registry with the consent of patients. Ms Graham confirmed that work is advanced to ensure hospital participation in the Breast and Cosmetic Implant Registry.

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

5.2.4 Are there safe practices in place for the inpatient services?

The arrangements for the provision of inpatient services were reviewed.

The inpatient unit is divided into two levels, level one for day surgery patients and level two for patients requiring to stay overnight.

A sample of patient care records were reviewed and confirmed that they included a contemporaneous note of each patients' medical history, medicine regime and treatment provided. However, it was identified that some patient care records were incomplete. The identified records were discussed with Ms Graham and assurances were received that these matters would be reviewed.

During a tour of some areas of the inpatient unit, it was observed that the clinical and decontamination areas were clean, tidy and uncluttered. It was identified that there were some matters requiring further attention. These areas were discussed with Ms Graham and following the inspection, RQIA received confirmation that these matters had been addressed.

There were hand hygiene facilities available throughout the unit. Hand hygiene practices of staff were observed and noted to be in keeping with best practice guidance. All areas of the inpatient units observed were equipped to meet the needs of patients.

An emergency trolley containing emergency medicines and equipment is located at the entrance to each of the inpatient units. Each trolley is checked daily, weekly and monthly by nursing staff. Emergency medicines were stored securely and oxygen was noted to be in date. There were separate adult and paediatric emergency medicines and equipment in place. It was noted that one of the emergency trollies had some items of the emergency equipment that had exceeded their expiry dates and required replacement. A review of the weekly checklist also identified that some items were missing and it was unclear of the action taken to replace the missing items. These areas were discussed with Ms Graham who confirmed that these areas would be addressed as a matter of priority. Following the inspection RQIA received confirmation that the identified areas had been actioned.

As a result of the actions taken and the assurances provided by Ms Graham, it was determined that safe practices were in place for the inpatient services.

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

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

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

A review of training records evidenced that authorised operators have up to date training in core of knowledge training and application training for the equipment in use. Following an area of improvement as a result of the inspection in April 2023, nursing staff present in theatre during the use of the laser equipment, had received laser training from a laser equipment supplier. However, it was unclear from the certificates provided if laser safety was a component of this training. It was noted that other staff such as radiographers and anaesthetists may also be present during the use of the laser in theatre.
All these staff known as assisting staff must have evidence of laser safety awareness training. In addition, staff who are in the theatre area, although not in the theatre during the use of the laser, must also have laser safety awareness training. Following the inspection RQIA received evidence that the LPA had devised a laser safety awareness course which is to be delivered by the Laser Protection Supervisor (LPS) to all the above staff. It was advised that oversight of laser safety training should be established and be readily accessible by the LPS. Following inspection evidence was submitted to RQIA confirming that oversight of laser training had been strengthened.

A review of the laser safety file found that it 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 UIC's LPA had completed a risk assessment of the premises during February 2024 and recommendations made were being addressed. Following the inspection evidence was submitted to RQIA to confirm that all recommendations had been fully addressed.

It was confirmed that laser surgical procedures are undertaken by the consultant urologists in accordance with medical treatment protocols produced by the consultant urologists. 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 in February 2024; which were updated following the inspection to reflect the full details of patient protective eyewear.

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 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 and should 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 inconsistently completed in relation to the above details. Advice was provided on the layout and content of the laser register to ensure accurate and consistent completion. Following the inspection, a new formatted laser register was submitted to RQIA which will allow for all of the above details to be consistently completed. It was also confirmed that the laser register will be subject to regular audit.

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. As stated previously the patient protective eyewear was reviewed and noted to be disposable eye shields, however, this was not reflected in the local rules. Following the inspection, the local rules were amended by the LPA to reflect patient protective eyewear accurately. The laser safety warning signs are displayed and also illuminated outside of the laser suite when the laser is in use. 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 October 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.

5.2.6 Estates

The following documentation in relation to the maintenance of the premises including mechanical and electrical services was reviewed. Discussion with UIC's Estates Manager and various estates staff demonstrated that suitable arrangements are in place for maintaining the environment in accordance with current legislation and best practice guidance. The following documents were reviewed:

- the 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 relating to the required weekly and monthly fire safety function checks
- records of fire drills undertaken
- Lifting Operations and Lifting Equipment Regulations (LOLER) 'Thorough Examination' reports of the premises' lifts and patient lifting equipment
- condition report for the premises' fixed wiring installation
- condition report for the formal testing of the premises' portable electrical appliances;
- the Legionella Risk Assessment
- service records and validation checks for the premises specialist ventilation systems, medical gases pipeline services and decontamination; and
- service records for the premises space heating boilers and emergency standby electrical generator

The premises' specialised ventilation systems and medical gas pipeline services, continue to be serviced and maintained in accordance with current best practice guidance. 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.

A current Legionella Risk Assessment was in place and suitable control measures for the premises hot and cold water systems were being undertaken with appropriate records being maintained. We established that a full chemical treatment of the premises' hot and cold water systems is undertaken annually. Regular bacteriological sampling of the hot and cold water systems is also regularly undertaken and appropriate action is taken when necessary.

The Fire Risk Assessment continues to be reviewed by a suitably accredited fire risk assessor. overall assessment of the risk assessment was assessed as 'tolerable' and the significant findings had been suitably addressed. Through discussion with staff we confirmed suitable fire safety training was being delivered and Staff demonstrated that they were aware of the action to be taken in the event of a fire.

Following a visual inspection of the premises, we found that the overall environment including the entrance, reception, bedrooms, theatres, treatment rooms and consultation rooms were being maintained to a high standard of decoration.

6.0 Quality Improvement Plan/Areas for Improvement

As a result of the prompt actions taken by UIC in response to the matters identified during this inspection no areas for improvement have been identified. Findings of the inspection were discussed with Ms Graham and the quality and education team as part of the inspection process and can be found in the main body of the report.

Appendix 1

Laser Protection Report

Site Details:
Ulster Independent Clinic
245 Stranmillis Road
Belfast
BT9 5JH

Laser Protection Adviser appointed by site:

Philip Loan, One Photon

Laser/IPL Equipment:

Make	Model	Class	Serial Number	Wavelength(s)
Cook Medical	Rhapsody H-30	4	LHT-05630416	2100nm (Ho:YAG)

Introduction
A Laser Protection Adviser (LPA) inspection of Ulster Independent Clinic was performed on 21 November 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:
The following points relating to the training & training records were discussed with the clinic on the day of inspection for remedial action:

A. Training Matrix

There was a discrepancy between staff who had signed laser manual and staff training records. Consideration should be given to developing a training matrix for laser staff to provide a clearer overview of training required and training completed.

B. Authorised Users

On the day of the inspection, there was no equipment training record available for one of the authorised laser users. Although it was noted that they had not used the laser since the last inspection, if they are to remain in the authorised users list, the LPS should ensure the relevant training records are available for this user.

C. Assisting Staff

Laser equipment training - some staff assisting during laser procedures had not completed laser equipment training.
Laser safety training - although a number of assisting staff had completed equipment training, it was not clear if this training included laser safety training. The clinic should ensure that all assisting staff have completed laser safety training at a level suitable for their role and this is clearly evidenced in the training records. Guidance on the level of laser safety training required for assisting staff can be found in section 3.7 of MHRA "Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices". Assisting staff include all supporting staff present in the laser controlled area including Radiographers and anaesthetists. All assisting staff should have up to date training in laser safety.

The clinic should ensure that training for laser staff is up to date and training records are maintained.

2. **Medical Treatment Protocol:**

Only one of eight authorised laser users has signed to indicate that they accept and understand the medical treatment protocol.

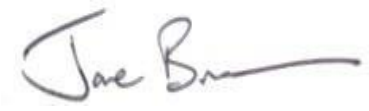
The clinic should ensure that authorised users have signed to accept both the local rules and medical treatment protocol.

3. **Patient Eye Protection:**

The eye protection used by the clinic for the patient was not specified in the local rules. The clinic should consult their LPA on this matter and if the LPA is satisfied that the eye protection is suitable, then the details should be added to the local rules.

4. **Laser Treatment Register (Log Book):**

The treatment date was missing from some records in the laser treatment register. To ensure consistency of information recorded the clinic should consider standardising the format of the treatment register.
The clinic should inform RQIA when the above points have been addressed.



Mrs Jane Brown
Laser Protection Adviser to RQIA

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews