

# Inspection Report

9 January 2025



## Cathedral Eye Clinic

Type of Service: Independent Hospital (IH) – Laser Eye Surgery  
Address: 89-91 Academy Street, Belfast, BT1 2LS  
Telephone number: 028 9032 2020

[www.rqia.org.uk](http://www.rqia.org.uk)

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Assurance, Challenge and Improvement in Health and Social Care

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

<p><b>Organisation/Registered Provider:</b> Cathedral Eye Clinic Ltd</p> <p><b>Responsible Individual:</b> Mr Jonathan Moore</p>	<p><b>Registered Manager:</b> Mrs Joyce Shaw</p> <p><b>Date registered:</b> 12 October 2022</p>
<p><b>Person in charge at the time of inspection:</b> Mrs Joyce Shaw</p>	
<p><b>Categories of care:</b> PT(L) Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers PT(IL) Prescribed techniques or prescribed technology: establishments using intense light sources PD Private Doctor AH (DS) Acute hospitals (day surgery only)</p>	
<p><b>Brief description of how the service operates:</b> Cathedral Eye Clinic is registered as an independent hospital (IH) with prescribed techniques or prescribed technology: establishments providing laser eye surgery using Class 3B or Class 4 lasers PT (L) and Intense Light sources PT(IL); private doctor (PD) and acute hospitals (day surgery only) AH (DS) categories of care.</p> <p><b>Laser equipment available in the service</b></p> <p><b>Floor 1 YAG Room:</b> Manufacturer: Quantel Medical Model: Optimis Fusion Serial Number: 62-07-0200 Output wavelength: 532 &amp; 1064nm Laser Class: 3B</p> <p>Manufacturer: Quantel Medical Model: Vitra 2 Serial Number: 3434 Output wavelength: 532nm Laser Class: 4</p> <p><b>Floor 2 Laser Suite:</b> Manufacturer: Schwind-Amaris Serial Number: A779 Output wavelength: ArF (193nm) Laser Class: 4</p>	

Manufacturer: Zeiss  
 Model VISUMAX  
 Serial Number: 9511100214  
 Output wavelength: 1043nm  
 Laser Class: 3B

**Floor 2 Cataract Suite:**

Manufacturer: D.O.R.C  
 Model EVA  
 Serial Number: 2015000298  
 Output wavelength: 532nm  
 Laser Class: 4

**Floor I**

**IPL equipment:**

Manufacturer: Topcon (Espansione Marketing SpA)  
 Model: Eye-Light  
 Serial number: EYCD7CC6F7131K  
 Laser wavelength: 600nm filter

**Type of Treatments Provided:**

Laser and Intense Pulse Light (IPL) eye surgery and other vision correction treatments:

- LASEK
- LASIK
- Cross-Linking
- Presbymax
- VISUMAX SMILE
- SLT Laser treatments
- Transepi PTK
- Glaucoma
- Vitrectomy procedures
- Capsulotomy
- Dry eye procedures

## 2.0 Inspection summary

This was an announced inspection undertaken by three care inspectors on 9 January 2025 from 10.00 am to 5.00 pm. RQIA's laser protection advisor (LPA) from the Belfast Health and Social Care Trust, supported the inspection and reviewed details of the laser and IPL equipment and the associated safety arrangements. Their findings 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 and IPL 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.

During the inspection a tour of the premises was undertaken and the inspectors met with Mr Moore, Responsible Individual and some staff members. This inspection was facilitated by Mrs Shaw, 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?**

Patient feedback was assessed by reviewing the most recent patient satisfaction surveys completed by Cathedral Eye Clinic.

Posters were issued to Cathedral Eye Clinic by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire.

Five patients submitted responses. Patient responses indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led. Four of the patients indicated that they were very satisfied with each of these areas of their care. One patient indicated that they were very dissatisfied however, this may have been recorded in error as their comments were positive regarding their overall experience. A number of patient responses included additional comments in which they stated that the service and treatment they received was excellent, and they were treated by caring, professional and efficient staff.

One staff member submitted questionnaire responses. The staff member's responses indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. They indicated that they were very satisfied each of these areas of patient care.

The staff member included additional comments in which they stated that the clinic had a strong leadership ethic which was patient centred, the patients' needs were taken into consideration and the management were approachable and proactive.

## **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 Cathedral Eye Clinic was undertaken on 11 January 2024; no areas for improvement were identified.

## **5.2 Inspection outcome**

### **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. This includes a team of consultant ophthalmologists, anaesthetists, optometrists, registered nurses and laser technicians who have evidence of specialist qualifications and skills in refractive laser eye surgery.

Regulated establishments are required to maintain a staff register. A staff register was in place which was found to be up to date and included information of all current staff and also those who had previously worked in the establishment. Mrs Shaw was aware that the staff register is a live document and should be updated and amended as and when required.

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, in the main, staff had undertaken training in keeping with [RQIA training guidance](#) and legislation. It was identified that the fire safety awareness refresher training for some of the staff had not been undertaken annually this was discussed with Mrs Shaw. Following the inspection RQIA received confirmation that this issue would be addressed.

A review of records confirmed that induction programmes are available and had been completed for new staff members and were relevant to their roles and responsibilities.

Discussion with Mrs Shaw in conjunction with a review of documentation confirmed that robust arrangements were in place to check the registration status for all clinical staff on appointment and on an ongoing basis. The arrangement for monitoring the professional indemnity of all staff was also in place, as was a system for monitoring any practising privileges agreements.

Discussions with staff demonstrated a highly motivated team who felt valued. Staff spoke of effective team work in the clinic where they felt supported by senior management at all times.

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.

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

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

A review of three personnel files of staff recruited since the previous inspection and discussion with Mrs Shaw confirmed that recruitment documentation as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 had been sought and retained. Mrs Shaw was advised on the management of AccessNI disclosure certificates in line with the AccessNI code of practice.

The recruitment policy and procedure in place adhered to legislation and best practice guidance. Mrs Shaw agreed to further develop this policy to include the name of the person responsible for recruitment of staff and details of health checks of staff.

It was determined that recruitment and selection procedures are in place that will 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 Shaw stated 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. Discussion with staff confirmed that they 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 lead named in the policy had completed safeguarding training at the level required in keeping with the [NI Adult Safeguarding Partnership Training Strategy 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.

A review of the management of medical emergencies policy identified that it accurately reflected the arrangements that were found to be in place for managing 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, local anaesthetic toxicity kit and endophthalmitis kit found that systems were in place to ensure that emergency medicines and equipment do not exceed their expiry dates 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.

Discussion with staff confirmed that the management of medical emergencies is included in the induction programme. A review of training records evidenced that staff had completed basic life support training and two members of theatre staff had completed advanced life support training.

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. Mrs Shaw is aware that the Department of Health (DOH) and Public Health Agency (PHA) websites provide advisory information, guidance and alert with regards to IPC.

It was evidenced that a robust programme of IPC auditing was in place. The most recent IPC audit undertaken by an external consultant dated 1 October 2024 was reviewed and any recommendations made had been actioned.

A tour of the premises was undertaken and the clinic was found to be clean, tidy and uncluttered. Cleaning records were completed and up to date. Staff described the arrangements to decontaminate the environment and equipment between patients in keeping with best practice.

A review of training records confirmed that staff had received IPC training commensurate with their roles and responsibilities. Staff demonstrated good knowledge and understanding of IPC procedures.

The theatre manager who is also the IPC lead informed us that most medical devices used in surgery are single use and some reusable medical devices are also used during cataract surgery. It was confirmed that arrangements were in place to ensure the decontamination of equipment and reusable medical devices is in line with manufacturer's instructions and current best practice. Cathedral Eye Clinic has a contract in place with the Central Sterile Services Department (CSSD) of the Ulster Hospital for this purpose.

Personal protective equipment (PPE) was readily available in keeping with best practice guidance.

Waste management arrangements were in place and clinical waste bins were pedal operated in keeping with best practice guidance.

The laser suite and treatment rooms provided dedicated hand washing facilities and hand sanitiser was available throughout the clinic.

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

#### **5.2.6 How does the service ensure that laser procedures are safe?**

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

A review of the laser safety files found that they contained all of the relevant information in relation to most of the laser equipment in place. A new laser Zeiss VISUMAX serial number: 9511100214 had been installed replacing the previous Zeiss VISUMAX laser. It was noted that the laser safety file for the Zeiss VISUMAX serial number: 9511100214 contained information relating to the previous Zeiss VISUMAX laser. It was advised to archive information relating to the previous laser unless deemed relevant to the new laser by the LPA for example the local rules. Management gave assurances on this matter.

The written confirmation of the appointment and duties of a certified LPA which is reviewed an annual basis was not available on the day of inspection. However, this was submitted to RQIA following the inspection. The service level agreement between the clinic and the LPA had been reviewed and was up to date.

The clinic's LPA completed a risk assessment of the premises during February 2024 and no recommendations were made.

It was confirmed that laser eye procedures are carried out by the consultant ophthalmologists and IPL eye procedures by optometrists, acting as the authorised operators. A register of authorised operators for each laser and IPL machine is maintained. The medical director for Cathedral Eye Clinic has developed a formal oversight system of the authorised operators who are consultant ophthalmologists, it was advised that this should be extended to the optometrists who act as authorised operators. The medical director who is the responsible individual confirmed that he would act on this advice.

The LPS confirmed that the consultant ophthalmologists and optometrists undertake laser and IPL eye surgical procedures in accordance with medical treatment protocols produced by three resident consultant ophthalmologists and systems were in place to review the medical treatment protocols on an annual basis. It was advised to ensure the medical treatment protocols content reflects the headings as outlined in standard 48.3 of [Minimum Care Standards for Independent Healthcare Establishments \(July 2014\)](#). Mr Moore and senior management gave assurances on this matter.

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 and IPL equipment being used. Arrangements were in place to review the local rules on an annual basis. Records reviewed demonstrated all authorised operators and persons involved in the laser service had signed to confirm that they had read and understood the relevant local rules.

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

The LPS 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 and IPL surgical registers found them to be overall well completed.

It was noted that the new laser Zeiss VISUMAX serial number: 9511100214 procedures had been recorded in the previous Zeiss VISUMAX laser register. There was no formal demarcation in the laser register reflecting when the laser register record began recording the procedures provided using the new laser. It was advised to amend the laser register to reflect the new laser details and the commencement date of the provision of procedures using the new laser to ensure accuracy of recordings. Management agreed to amend this accordingly. It was confirmed that the laser registers will be subject to regular audit to confirm compliance.

The laser suite and treatment rooms where the laser and IPL equipment is used were found to be safe and controlled to protect other persons while treatment is in progress. The LPS and theatre manager confirmed that the doors to the controlled areas are locked, when the laser equipment is in use, but can be opened from the outside in the event of an emergency.

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

Staff confirmed that protective eyewear was available if required. The protective eyewear for the laser and IPL equipment was reviewed and found to be in accordance to the local rules.

The laser safety warning signs are illuminated outside of the laser suite and the treatment rooms when the laser and IPL equipment is in use and turned off when not in use, as described within the local rules.

Arrangements have been established for equipment to be serviced and maintained in line with the manufacturers' guidance. The most recent service reports were reviewed. The installation report for the new Zeiss VISUMAX laser was not available on the day of inspection. Following the inspection an electronic copy of the Zeiss VISUMAX installation certificate was submitted to RQIA and found to be in order.

Carbon dioxide (CO<sub>2</sub>) 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.

It was determined that appropriate laser and IPL safety arrangements were in place to ensure patients have safe and effective laser and eye surgical procedures.

### **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 an initial consultation with an optometrist who discusses their treatment options and the cost of the surgery.

During the 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 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 meet 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 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 if necessary.

Staff informed us that systems were in place to review the patient following surgery in accordance treatment protocols and longer if necessary.

Five patient care records reviewed were found to be well documented, contemporaneous and clearly outlined the patient journey.

The management of 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 governance?**

#### **Organisational governance**

Various aspects of the organisational and medical governance systems were reviewed and evidenced a clear organisational structure within Cathedral Eye Clinic.

As previously outlined, Mr Moore is the responsible individual in the clinic and Mrs Shaw is the registered manager. An organisational structure was in place with clear lines of accountability, defined structures and visible leadership and staff were aware of these.

During our review of minutes of meetings and policy documents it was noted that a member of the management team was referenced by way of two different job titles none of which was the same as their job title as stated in the organisational chart (organogram). This was discussed with Mr Moore and Mrs Shaw who were receptive to this observation and agreed to review the documents to ensure job titles within the clinic's documents align with the organisational structures.

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. Mr Moore works as a consultant ophthalmologist and acts as the clinical director for the service and is supported by Mrs Shaw who oversees the day to day operation of services. It was established that Mr Moore remains in day to day charge of the service, therefore the unannounced quality monitoring visits by the registered provider were not applicable.

The clinic has a clinical governance committee (CGC) which is made up of members of the senior management team. The CGC is responsible for ensuring that quality improvement systems are working well across the organisation. The CGC meet on a quarterly basis and minutes were available to review.

A programme of weekly meetings also takes place which includes all departments within the clinic; meeting minutes detail the outcomes with time limited actions and the identified persons to address each action point. Discussion with staff and a review of records evidenced that staff meetings take place regularly and minutes were available for review.

The clinic uses a variety of means to share organisational learning with staff to include; power point presentations; discussion at safety briefs and handovers; emails; memorandums; posters; and educational events.

Policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, dated and systematically reviewed on a three yearly basis or more frequently if required.

Staff working in different roles within the clinic confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

### **Clinical and medical governance**

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 Cathedral Eye Clinic is registered with the GMC as a designated body and have an appointed RO.

As discussed Cathedral Eye Clinic has a clinical governance committee that meets on a quarterly basis. The clinical governance committee is chaired by the RO and is attended by consultant ophthalmologists, the theatre manager, the human resources manager and Mrs Shaw.

Cathedral Eye Clinic also has a medical advisory committee (MAC) that includes the clinical director, the RO and other members of the organisation's senior management team. Mrs Shaw was advised to ensure that the MAC meets at least quarterly and that the terms of reference include a review of practising privileges. Following the inspection RQIA received confirmation that these issues had been addressed.

There are four consultant ophthalmologists who 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 General Practitioner's (GP's) performer list in NI. Review of the four consultant ophthalmologists' 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

As previously discussed the consultant ophthalmologists had completed training in accordance with RQIA's training guidance for private doctors however, the fire safety awareness training had not been undertaken annually for some of the consultants. This was discussed and addressed following the inspection.

## **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. It was suggested that the policy is further strengthened to outline roles and responsibilities should a consultant's practicing privileges agreement be restricted, suspended or withdrawn. Mr Moore confirmed that the granting, review, restriction, suspension or withdrawal of practising privileges is a function of the MAC and also stated that this policy would be further developed as discussed.

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

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 results of audits are analysed 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.

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

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

## **Notifiable Events/Incidents**

A robust system was in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies as appropriate.

Mrs Shaw 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. An audit would be maintained, reviewed and the findings presented to the directors during their quarterly meetings.

**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 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 any 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. Discussion with Mrs Shaw and staff confirmed that the management of complaints is reviewed on a weekly basis. A formal regular over-arching review of complaints to identify trends or themes emerging had been implemented since the previous inspection.

It was demonstrated that information gathered from complaints will be used to improve the quality of services provided.

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

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

**6.0 Quality Improvement Plan/Areas for Improvement**

	Regulations	Standards
<b>Total number of Areas for Improvement</b>	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mr Moore, Mrs Shaw, and other members of staff as part of the inspection process and can be found in the main body of the report.

## Appendix 1

### Laser Protection Report

#### Site Details:

Cathedral Eye  
89-91 Academy Street  
Belfast  
BT1 2LS

#### Laser Protection Adviser appointed by site:

Anna Bass, Lasermet

Laser/IPL Equipment: Make	Model	Class	Serial Number	Wavelength(s)
Quantel	Optimus Fusion	3B	62-07-0200	532 & 1064 nm
Quantel	Vitra 2	4	3434	532 nm
Schwind	Amaris	4	A779	193 nm (ArF)
Zeiss	Visumax 800	3B	9511100214	1043 nm
D.O.R.C	EVA	4	2015000298	532 nm
Topcon (Espansione Marketing SpA)	Eye-Light	Risk Group 3	EYCD7CC6F7 131K	User Manual specifies OPE Lamp with 600nm filter

#### Introduction

A Laser Protection Adviser inspection of Cathedral Eye was performed on 9 January 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. Authorised Users Register:** The Authorised Users Register was not updated when new users were approved or existing users were authorised for additional lasers. The register was not consistent with the authorised user signatures in the local rules.

The clinic should ensure that a review of the Authorised Users Register is undertaken regularly, and updates made to reflect any changes to the authorised users.

**2. Medical Treatment Protocols:** The clinic should ensure the treatment protocols are reviewed to ensure that they all follow the relevant headings in standard 48.3 of the Minimum Care Standards for Independent Healthcare Establishments.

**3. Zeiss Visumax 800:** A replacement Zeiss Visumax laser was installed in 2024, mid-year. Following the installation, the clinic's LPA had confirmed that the existing risk assessment and local rules were still valid. The clinic also confirmed there were no changes required to the treatment protocols. During the inspection visit, the following issues were identified and should be addressed by the clinic:

a) Installation Report: There was no installation report available for the new Zeiss Visumax 800 laser. The clinic should ensure they have an installation report for the new laser and file a copy in the laser safety file.

b) Treatment Register: It was unclear from the treatment register when the new laser was placed into clinical service as only the serial number of the old laser was recorded on the front cover of the treatment register and there was no information recorded in the register regarding the change of laser. The clinic should ensure the treatment register is updated with information clearly showing when the old laser was decommissioned and the new laser introduced.

c) Laser Safety File: The clinic should remove the documents that relate solely to the decommissioned laser from the laser safety file e.g. service records.

**4. LPA Certificate:** It is considered good practice for the clinic to keep a copy of their LPA's certification certificate in the laser safety file.

**5. Gas Leak Procedures:** The clinic should review their laser safety documentation and ensure that procedures in the event of a gas leak are documented.

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



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](mailto:info@rqia.org.uk)  
**Web** [www.rqia.org.uk](http://www.rqia.org.uk)  
**Twitter** @RQIANews