The Regulation and Quality Improvement Authority

Inspection Report

30 January 2025

In-OVO Fertility Clinic

Type of Service: Independent Hospital (IH)
Fertility Services and Assisted Conception
Address: Unit 1,189 Airport Road West, Portside Business Park, Belfast, BT3 9ED
Telephone Number: 028 9620 7100

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

Organisation/Registered Provider: In-OVO Fertility Clinic Ltd **Responsible Individual:** Dr Efstathios Diakos	**Registered Manger:** Ms Melanie Stanton **Date registered:** 17 September 2020
Person in charge at the time of inspection: Ms Melanie Stanton	
Categories of care: Independent hospital (IH) Prescribed techniques or prescribed technology: clinics providing in vitro fertilisation techniques PT (IVF) Private doctor (PD)	
Brief description of how the service operates: In-OVO Fertility Clinic is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital (IH) with prescribed techniques or prescribed technology: clinics providing in vitro fertilisation techniques PT (IVF) and private doctor (PD) categories of care.	

2.0 Inspection summary

A short notice announced inspection was undertaken to In-OVO Fertility Clinic, which commenced with an onsite inspection on 30 January 2025 from 10.00 am to 3.30 pm and included a request for the submission of information electronically.

The onsite component of the inspection was completed on 30 January 2025 by three care inspectors and one pharmacist inspector. Feedback of the onsite inspection findings was delivered to Ms Melanie Stanton, Registered Manager, on the day of the inspection.

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

A multidisciplinary inspection methodology was employed during this inspection and the inspection team met with various staff members; reviewed care practices; and reviewed relevant records and documentation used to support the governance and assurance systems. Medication management was reviewed during the inspection to determine if medicines were managed safely and effectively.

It was determined that staffing levels and morale in the clinic were good; with evidence of good multidisciplinary team working and open communication between staff. Staff feedback was positive and it was evident that there were good working relationships.

Examples of good practice were evidenced in respect of: staffing; staff training; recruitment and selection of staff; safeguarding; the provision of assisted conception services; management of the patients' care pathway; management of medical emergencies; infection prevention and control; medicines management; maintenance of the environment; engagement to enhance the patients' experience; and organisational and clinical governance.

No immediate concerns were identified in relation to patient safety and the inspection team noted areas of good practice in relation to the delivery of assisted fertility and conception services.

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.

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 quality improvement plan (QIP).

Prior to the inspection we reviewed a range of information relevant to the clinic. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the establishment
- written and verbal communication received since the previous care inspection
- the previous care inspection report

One week prior to the onsite inspection, In-OVO Fertility Clinic was provided with a list of specific documents requesting items to be reviewed remotely in respect of the maintenance of the premises and grounds. These items were to be sent electronically to the RQIA's estates inspector on or before 10 February 2025 for review.

The onsite component of the inspection was completed on 30 January 2025. The onsite inspection team examined a number of aspects of the clinic's services as outlined in section 2.0 of this report. The team undertook a tour of the premises and met with various staff members and reviewed relevant records and documentation.

4.0 What people told us about the service.

The inspection team did not have the opportunity to speak with patients during the inspection.

Ms Stanton confirmed that satisfaction surveys are completed by patients following their treatment and the findings are shared through their governance structures. A review of a recent patient satisfaction survey completed during 2024 demonstrated that In-OVO Fertility Clinic pro-actively seek the views of patients and their partners about the quality of care, treatment and other services provided. Patient feedback regarding the fertility service was found to be very positive in respect to all aspects of care received and reflected that staff deliver a very high standard of care. Ms Stanton confirmed that an action plan would be developed to inform and improve services provided, if appropriate. Advice and guidance was given regarding collating the results of the satisfaction surveys to provide an anonymised summary report which is made available to patients and other interested parties. Ms Stanton agreed to action this following the inspection.

Posters were issued to In-OVO Fertility Clinic by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire. No completed patient or staff questionnaires were submitted to RQIA prior to or following the inspection.

5.0 The inspection

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

The last inspection to In-OVO Fertility Clinic was undertaken on 17 January 2024; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 How does the establishment ensure that safe staffing arrangements are in place to meet the needs of patients?

Staffing arrangements were reviewed and it was confirmed that there are appropriately skilled and qualified staff involved in the delivery of services. This includes Dr Diakos, Responsible Individual and Medical Director, Ms Stanton, Registered Manager, three consultant anaesthetists, a team of embryologists and registered nurses who have completed specialist qualifications and can demonstrate competency in fertility treatments.

We reviewed the arrangements for the oversight and recording of induction and on-going training to ensure all staff working in In-OVO Fertility Clinic receive mandatory training and other training, supervision and appraisal in accordance with best practice guidance. A training matrix was in place to monitor the status of all staff training requirements.

Arrangements were in place for staff to take part in ongoing training to update their knowledge and skills, relevant to their role. A review of the training records evidenced that the majority of staff had undertaken training in keeping with RQIA training guidance and legislation. It was noted that training records were not in place for some of the consultant anaesthetists to verify that they had completed training as outlined in the RQIA training guidance. This was discussed with Dr Diakos and Ms Stanton and following the inspection RQIA received confirmation that this issue had been addressed.

Ms Stanton confirmed that when a new member of staff is recruited they take part in an induction and undertake training commensurate with their roles and responsibilities. An induction programme had been developed for each new member of staff which was relevant to their roles and responsibilities.

Ms Stanton confirmed that the nursing staff receive regular professional clinical supervision and competency assessments form part of the supervision sessions.

Discussion with Ms Stanton and review of documentation identified that arrangements were in place to check the registration status for all clinical staff on appointment, for example: medical practitioners with the General Medical Council (GMC) and nursing staff with the Nursing and Midwifery Council (NMC).

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 establishment ensure that recruitment and selection procedures are safe?

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

Recruitment and selection policies and procedures were in place, which adhered to legislation and best practice guidance. These arrangements will ensure that all required recruitment documentation has been sought and retained for inspection.

A staff register was available to review which was up to date and included the names and details of all staff who are and have been employed, in keeping with legislation. The staff register evidenced that two staff members had been recruited since the previous inspection.

A review of the personnel files for the newly recruited staff evidenced that all the relevant information as listed in Regulation 19, Schedule 2 of the Independent Health Care Regulations (NI) 2005, as amended, had been sought and retained.

Robust recruitment and selection procedures were in place to ensure compliance with the legislation and best practice guidance.

5.2.3 Are the arrangements in place for safeguarding in accordance with current regional guidance?

The arrangements in respect of the safeguarding of adults and children were reviewed. Ms Stanton confirmed that treatments are not provided to persons under the age of 18 years.

A policy and procedure was in place for the safeguarding and protection of adults and children at risk of harm. The policy 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. Advice and guidance was provided to ensure that the policy is in keeping with the regional guidance and following the inspection RQIA received confirmation that this had been addressed.

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

Staff spoken with 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 identified safeguarding champion had completed safeguarding training at the level required in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016) and minimum standards.

It was confirmed that a copy of the regional guidance document entitled Adult Safeguarding Prevention and Protection in Partnership (July 2015) was available for reference.

It was demonstrated that appropriate arrangements were in place to manage a safeguarding issue should it arise.

5.2.4 Does the establishment adhere to best practice guidance concerning the management of patients undergoing fertility treatment?

In-OVO Fertility Clinic is licensed with the Human Fertilisation and Embryology Authority (HFEA), the UK's independent regulator for the fertility sector. The clinic has held a Treatment and Storage license with the HFEA since 2020 and provides a full range of fertility services.

A range of treatment protocols were in place for the management of patients receiving assisted conception services which have been developed and agreed by all professionals within the clinic. It was identified that the protocols examined included issue and review dates.

The protocols for the prevention and management of ovarian hyper stimulation syndrome (OHSS) have been written by the lead clinician, a review of these protocols demonstrated that they were evidence based and in line with best practice.

It was confirmed that written protocols are in place for the close monitoring of patients, in order to avoid unnecessary complications including multiple pregnancies.

An elective single embryo transfer (eSET) protocol, titled 'Multiple Birth Minimisation Strategy' was in place. It was confirmed that the eSET protocol sets out the number of embryos that can be placed in a patient in any one cycle and this protocol complies with the HFEA code of practice. The protocols and procedures were discussed with the staff who demonstrated detailed knowledge on the matter.

It was confirmed that the clinic has a procedure for indelible labelling of material for individual patients to ensure the unique identification of a patient's material and the checking and recording of all stages of treatment.

There was evidence that there is suitable counselling regarding treatment and outcomes and there was documentation to reflect this. Staff confirmed that patients and their partners are treated with respect, dignity and compassion.

A daily multidisciplinary clinical meeting on the management of patients takes place and any recommended changes to treatment plans are agreed. During our inspection we observed this meeting taking place which was attended by Dr Diakos, Ms Stanton, the registered nurses, the laboratory manager, the senior embryologist and the receptionist.

A review of a selection of patients' clinical records found that all records were well completed and clearly outlined the patient pathway.

Discussion with staff and review of relevant policies and procedures evidenced that In-OVO Fertility Clinic were adhering to HFEA best practice guidance.

5.2.5 Is this establishment fully equipped and are the staff trained to manage medical emergencies?

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

The policy for the management of medical emergencies reviewed was in keeping with best practice. It included various protocols on the types of medical emergencies that may occur in the clinic in keeping with the Resuscitation Council (UK) guidelines.

A review of medical emergency arrangements evidenced that emergency medicines were provided in keeping with the British National Formulary (BNF), and emergency equipment as recommended by the Resuscitation Council (UK) guidelines was retained.

A record of all emergency medicines and equipment was attached to the emergency trolley and a written record is retained of the daily and monthly checks carried out by a designated member of staff.

Ms Stanton confirmed that the staff have knowledge and understanding of managing resuscitation and other medical emergencies and were aware of the location of medical emergency medicines and equipment.

A review of training records confirmed staff have received either first aid or basic life support training, nurses have undertaken immediate life support training and anaesthetists have advanced life support skills.

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.

5.2.6 Does the establishment adhere to infection prevention and control (IPC) best practice guidance?

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. The clinic had an overarching IPC policy and various associated procedures in place.

A tour of the premises was undertaken and the clinic was found to be clean, tidy and uncluttered. Overall, the equipment was found to be clean, free from damage and in good repair.

Clinical hand washing sinks located in each consulting room and other clinical areas were clean and used for hand hygiene practices only. A hand hygiene poster was displayed close to each hand washing sink. Staff were observed carrying out hand hygiene in accordance with best practice.

Hand sanitisers were readily available for staff and patient use throughout the clinic. Personal Protective Equipment (PPE) was readily available in keeping with best practice guidance. No reusable medical devices are used in the clinic and staff confirmed that contracts are in place to launder bedlinen.

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

Cleaning records were completed and found to be up to date and staff had undertaken IPC training commensurate with their roles and responsibilities. A colour coded cleaning system was in place and staff were aware of best practice guidance in this regard.

It was identified that whilst an IPC audit had been undertaken, a more robust audit programme should be developed on all aspects of IPC within the clinic in keeping with best practice. Following the inspection RQIA received confirmation that the audit programme will be further developed accordingly.

As stated previously, staff have undertaken mandatory IPC training. It was confirmed that IPC training also includes Aseptic Non Touch Technique (ANTT) training. As discussed in section 5.2.1, consultant anaesthetists' training arrangements have been addressed internally.

The arrangements in place to adhere to IPC best practice guidelines were found to be satisfactory.

5.2.7 Does the establishment adhere to best practice guidance concerning the management of medicines, including controlled drugs?

Written policies and standard operating procedures for the management of medicines, including controlled drugs, were in place. There was evidence these were routinely reviewed and updated. A system was in place to ensure all staff involved in the management of medicines had read and understood the policies and procedures.

There were safe arrangements in place for the stock control and storage of medicines. Medicines were ordered on requisition forms signed by Dr Diakos, with separate forms for controlled drugs. Medicines for use in the clinic were supplied by the community pharmacist.

Only medicines used in theatre and recovery, for example, analgesia, sedatives, local anaesthetics, antibiotics and emergency medicines, were held in the clinic. Systems were in place to manage the ordering of these medicines and to ensure adequate supplies were available. Medicines for use at home were prescribed by Dr Diakos and obtained directly by patients from a specialist pharmacy supplier. If top-up prescriptions of fertility medicines were required, a private prescription signed by Dr Diakos, was issued to the patient and an arrangement was in place with a local community pharmacy to stock and dispense these medicines promptly.

There was suitable counselling regarding treatment and outcomes and documentation to reflect this. Patients were provided with information regarding their treatment and the medicines prescribed; this included detailed advice on the purpose of the medicines, how to administer them at home and any potential side effects. This information was given verbally, in paper form and electronically. Any changes to treatment were communicated to patients both verbally and electronically and records were maintained.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions, in the locked cupboard in theatre. A controlled drug cabinet and a medicine refrigerator were available. Temperatures of the medicine storage were monitored to ensure medicines were stored according to the manufacturers' instructions. Satisfactory arrangements were in place for the disposal of medicines.

The management of controlled drugs was in compliance with legislative requirements, professional standards and guidelines. A controlled drug licence, issued by the Medicines Regulatory Group at the Department of Health, was in place. The Accountable Officer (AO) is responsible for the management of controlled drugs and related governance issues in their organisation; the Accountable Officer for In-OVO Fertility Clinic is Ms Stanton and this was reflected in the controlled drugs policy. Satisfactory arrangements were in place for the destruction of controlled drugs, with denaturing kits available for this purpose.

Systems were in place to ensure training on medicines management was provided for relevant staff. Refresher training was provided and competencies were reassessed following any medication related incidents or if a need was identified through the audit process.

Systems were in place for the management of drug and medical device alerts issued by the Medicines and Healthcare Regulatory Agency (MHRA). Ms Stanton maintains a database of all alerts received and the action taken.

An effective incident reporting system was in place to identify, record, report and share learning from any medicine related incidents. Medicine related incidents are reported to RQIA and any which involve controlled drugs are also reported to the Local Intelligence Network.

Arrangements were in place to audit the management of medicines. Evidence of this activity was maintained. This included a monthly controlled drugs audit, a monthly review of patient records and stock level and date checking for the medicines held in theatre.

5.2.8 How does the service ensure the environment is safe?

The management of the environment component of this inspection was completed remotely. The management team of the clinic were provided with a checklist of estates related documents to submit to the estates inspector for review.

Certification relating to the maintenance and upkeep of the building and engineering services as well as relevant risk assessments were submitted, including:

- 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
- condition reports for the premises fixed wiring electrical installation
- legionella risk assessment, water safety plan and records of control measures
- service records and test reports for the premises piped medical gas systems
- service records and test reports for the premises specialist ventilation
- service records for the emergency standby generator

The current legionella risk assessment was undertaken on 25 November 2024 and remains valid. The control measures outlined in the water safety plan continue to be implemented, with suitable temperature monitoring of the premises' hot and cold water systems being maintained as recommended.

A fire risk assessment had been undertaken by a suitably accredited fire risk assessor. This will be reviewed on 11 March 2025. It is important that any required actions flowing from this assessment are signed off as completed within the stipulated time frames. Fire safety records inspected, confirmed that all systems were maintained in accordance with current best practice guidance. Regular fire drills and fire safety training continue to be undertaken.

The premises critical ventilation systems and specialist gas pipeline services are being maintained in accordance with current best practice guidance. These were inspected by the HFEA and found to be acceptable in accordance with their approved code of practice. Records and validation reports were available and inspected at the time of the inspection.

The premises' space and water heating services are fully maintained and serviced in accordance with best practice guidance. These include the service and testing of the premises' emergency standby electrical generator and gas detection systems.

All areas of the establishment were found to meet the needs of patients.

5.2.9 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 In-OVO Fertility Clinic.

Dr Diakos is the responsible individual and the only private doctor working in the clinic and is supported by Ms Stanton as the registered manager.

In-OVO Fertility Clinic has a board of directors that includes Dr Diakos as the clinician. Other shareholders of the organisation attend the board of director's meetings and they meet quarterly.

Discussion with staff and a review of records evidenced that staff meetings take place regularly and minutes were available to review. Daily clinical meetings also take place and are attended by Dr Diakos, Ms Stanton, an anaesthetist, the embryologists, nursing staff and administrative staff. On the day of the inspection the inspectors had the opportunity to observe the daily clinical meeting.

A sample of minutes from several meetings reviewed evidenced that the governance structures were functioning well to provide a level of assurance to the board of directors.

Where the business entity operating an assisted fertility 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. Dr Diakos, Responsible Individual, is in day to day management of the service; therefore, unannounced quality monitoring visits are not required.

Medical governance and practising privileges

The governance, medical leadership and medical cover within the clinic were discussed with Dr Diakos, medical director of In-OVO Fertility Clinic.

A review of records and discussion with Dr Diakos and Ms Stanton confirmed that a medical advisory committee (MAC) is in place. The terms of reference for the MAC were reviewed and these have been developed in accordance with the Minimum Standards for Independent Healthcare Establishments (July 2014). MAC meetings are minuted and minutes of the most recent MAC meetings provided a detailed account of the topics discussed and decisions made. Advice and guidance was given regarding the frequency of these meetings to ensure that they are undertaken at least quarterly in keeping with the standards. Following the inspection RQIA received confirmation that a MAC meeting had taken place on 3 February 2025 and assurances were given that these meetings will be held quarterly in the future.

Dr Diakos is the only wholly private doctor as he no longer holds a substantive post in the Health and Social Care (HSC) sector in NI and is not on the General Practitioner's (GP's) performer list in Northern Ireland (NI). Review of Dr Diakos details confirmed there was evidence of the following:

- confirmation of identity
- current GMC registration
- professional indemnity insurance
- qualifications in line with service provided
- ongoing professional development and continued medical education that meets the requirements of the Royal Colleges and GMC
- ongoing annual appraisal by a trained Medical Appraiser

- an appointed responsible officer (RO)
- arrangements for revalidation

Dr Diakos had completed training in accordance with RQIA's training guidance and is aware of his responsibilities under GMC Good Medical Practice.

All medical practitioners working within the clinic must have a designated RO. In accordance with the GMC all doctors must revalidate every five years. The revalidation process requires doctors to collect examples of their work to understand what they're doing well and how they can improve. Experienced senior doctors (called ROs) work with the GMC to make sure doctors are reviewing their work. As part of the revalidation process RO's make a revalidation recommendation to the GMC. Where concerns are raised regarding a doctor's practice information must be shared with their RO who then has a responsibility to share this information with all relevant stakeholders in all areas of the doctor's work.

The current arrangements supporting medical appraisal and revalidation with an RO for all medical practitioners working in the clinic was discussed. It was confirmed that the three consultant anaesthetists who work in In-OVO Fertility Clinic also hold a substantive post in the HSC sector in NI and complete their appraisal and medical revalidation through their employing organisations which are either local HSC Trusts or other HSC organisations. It was demonstrated that annual appraisals were in place for the three consultant anaesthetists and were up to date.

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. Dr Diakos informed us that the three consultant anaesthetists each work under a practising privileges agreement.

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

A review of the three consultant anaesthetist's personnel files evidenced that there was a written practicing privileges agreement between each consultant and In-OVO Fertility 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.

Quality assurance

It was evidenced that arrangements were in place to review risk assessments, a risk management register is maintained and reviewed with the directors on a regular basis.

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 and embedded into practice to address any shortfalls identified during the audit process. As discussed previously a more robust audit programme

should be developed on all aspects of IPC within the clinic in keeping with best practice. Following the inspection RQIA received confirmation that the audit programme would be further developed accordingly.

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.

The Statement of Purpose and Patient's Guide were kept under review, revised and updated when necessary and available on request.

The RQIA certificate of registration was up to date and 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.

A review of a notification submitted to RQIA since the previous inspection demonstrated that a system was in place to ensure that notifiable events were investigated and reported to RQIA, HFEA or other relevant bodies as appropriate within a timely manner.

Ms Stanton advised that any learning from incidents would be discussed during the daily and monthly meetings to ensure the dissemination of learning to all staff. Ms Stanton also advised that 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 by the senior management team 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 Department of Health (DoH) guidance on complaints handling. It was noted that the complaints policy outlined the roles and responsibilities of those delegated to manage complaints. This was also highlighted during the previous inspection and it was suggested at that time that the title of these roles align with staff member's titles as outlined within the In-OVO Fertility Clinic organisational structure. This was discussed and following the inspection RQIA received evidence that this issue had been addressed.

Ms Stanton 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.

It was confirmed that no complaints had been received since registration. Ms Stanton advised that any complaints received would be investigated and responded to appropriately to include details of all communications with complainants; the result of any investigation; the outcome and any action taken. Information gathered from complaints will be used to improve the quality of services provided.

It was determined that suitable arrangements are in place to enable Dr Diakos and the board of directors to assure themselves of the quality of the services provided in In-OVO Fertility Clinic.

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

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

6.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Stanton, Registered Manager, as part of the inspection process and can be found in the main body of the report.

The Regulation and Quality Improvement Authority

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