The Regulation and Quality Improvement Authority

Inspection Report

7 April 2025

Face Therapy NI Ltd

Type of service: Independent Hospital (IH) – Cosmetic Laser \ Intense Pulsed Light and Private Doctor
Address: 545 Antrim Road, Belfast, BT15 3BU
Telephone number: 078 1064 8887

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: Face Therapy NI Limited **Responsible Individual:** Ms Lisa Waring	**Registered Manager:** Ms Lisa Waring **Date registered:** 30 November 2023
Person in charge at the time of inspection: Ms Lisa Waring	
Categories of care: Independent Hospital (IH) Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers PT(L) and Prescribed techniques or prescribed technology: establishments using intense light sources PT(IL) Private Doctor (PD)	
Brief description of how the service operates: Face Therapy NI Ltd provides a range of cosmetic/aesthetic treatments. It is registered with the Regulation and Quality Improvement Authority (RQIA) as an Independent Hospital (IH) with the following categories of care: 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 and a private doctor (PD) service. On 27 August 2024, RQIA received a variation to registration application to add an AH (DS) - Acute hospitals (day surgery only) category of care. An extension has been built onto the current property existing of two treatment rooms, toilet, reception area and consultation room. The treatment rooms will be used for non-surgical and minor surgical day procedures. This application formed the basis of this on-site inspection.	

2.0 Inspection summary

This was an announced variation to registration inspection undertaken by two care inspectors on 7 April 2024 from 10.00 am to 2.00 pm.

An RQIA estates inspector reviewed the variation to registration application in regards to matters relating to the premises.

The purpose of the inspection was to review the readiness of Face Therapy NI Limited to provide minor surgical day procedures in the new extension.

During the inspection, inspectors reviewed a number of policies and procedures relating to the variation to registration application. The inspectors also reviewed the clinical environment from which the minor day surgical procedures proposed are to be performed, including the two newly built treatment rooms. An RQIA estates inspector also reviewed the variation to registration application in regards to matters relating to the premises remotely.

Based on the findings of the inspection and discussions held with the responsible individual, the variation to registration application was not approved at this point in time. Following the inspection, a further feedback meeting was held between RQIA and representatives from Face Therapy NI Ltd on 18 April 2025.

RQIA will continue to monitor the quality of care in Face Therapy NI Ltd and will complete a further on-site inspection to assess the variation to registration application in due course.

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 practice is operating in accordance with the relevant legislation and minimum standards.

Before the inspection a range of information relevant to the registration application was reviewed. This included the following records:

- the variation to registration application
- the proposed statement of purpose
- the proposed patient guide
- current and proposed floor plans
- documents pertaining to the new extension to the premises
- the previous inspection report dated 16 September 2024

During the inspection the inspectors met with Ms Waring, the clinic manager and a member of the day surgery nursing team.

Examples of good practice were acknowledged and any areas for improvement have been discussed with the person in charge and are detailed in the quality improvement plan (QIP).

4.0 The inspection

4.1 What action has been taken to meet any areas for improvement identified at or since last inspection?

The last inspection to Face Therapy NI Ltd was undertaken on 16 September 2024; one area for improvement was identified however, this was in regards to the provision of laser services and was not assessed at this inspection.

Areas for improvement from the last inspection on 16 September 2024		
Action required to ensure compliance with Minimum Care Standards for Independent Healthcare Establishments (July 2014)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 48.21 **Stated:** First time	The responsible individual shall ensure that the Laser Protection Supervisor (LPS) regularly reviews the laser safety file, to ensure that it is accurate, up to date and contains all of the relevant information in relation to laser and intense light equipment.	**Carried forward to the next inspection**
	Action to ensure compliance with this area for improvement was not reviewed during this inspection and has been carried forward for review at the next inspection.	

4.2 Inspection findings

4.2.1 Has the statement of purpose been developed in keeping with Regulation 7 Schedule 1 of the regulations?

A review of the statement of purpose identified that it largely reflected the key areas and themes specified in Regulation 7, Schedule 1 of The Independent Health Care Regulations (NI) 2005. The statement of purpose requires further development to include the range of minor day surgical day procedures to be provided by Face Therapy NI Ltd, which was discussed with Ms Waring during the inspection.

Ms Waring is aware that the statement of purpose should be reviewed and updated as and when necessary.

4.2.2 Has the patient guide been developed in keeping with Regulation 8, of the regulations?

A review of the patient guide identified that it largely reflected the key areas and themes specified in Regulation 8 of The Independent Health Care Regulations (NI) 2005. Advice and guidance was provided to Ms Waring during the inspection to further develop the patient guide to include the range of minor day surgical procedures to be provided.

Ms Waring is aware that the patient guide should be reviewed and updated as and when necessary.

4.2.3 How does the service ensure that staffing levels are safe to meet the needs of patients?

Staffing arrangements for the minor day surgery procedures were reviewed and discussed with Ms Waring, the clinic manager and the lead nurse for minor day surgery.

It was confirmed by Ms Waring that the following minor day surgical procedures are proposed:

- Upper and lower blepharoplasty
- Excision of skin lesion(s)
- A number of cosmetic procedures that may require aspiration/targeted liposuction.

Ms Waring also confirmed that other day surgery procedures (labiaplasty, hair transplantation and gender affirming facial procedures) may be offered in the future, pending recruitment of suitably trained medical practitioners. Ms Waring is aware that prior to Face Therapy NI Limited offering additional minor surgical procedures they must consult with RQIA.

The clinical team who will provide the minor surgical procedures include a private doctor, registered with the General Medical Council (GMC), and a lead nurse. The clinical team will be supported in the scheduling and running of the clinic by administration staff and clinic management.

A review of the details of the private doctor's record evidenced that the following had been sought:

- confirmation of identity
- current GMC registration
- qualifications in line with the surgical 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
- arrangements for revalidation
- professional indemnity insurance

The recruitment of private doctors was discussed. Ms Waring was advised that, as a pre requisite to granting practicing privileges for any doctor, she must be satisfied that all necessary checks have been successfully completed, and be able to provide evidence to this effect.

Whilst a practising privileges policy pertaining to private doctors was available for review, there was no individual signed practising privileges agreement for the identified private doctor. This matter is discussed further in section 4.2.12.

A review of training records evidenced that the medical practitioner had completed practical training in aesthetic medicine and plastic surgery and is named on the GMC specialist register in plastic surgery.

All staff had completed basic life support, IPC, fire safety awareness and safeguarding adults and children at risk of harm training in keeping with the RQIA training guidance.

Through discussion and review of relevant documentation, it was confirmed that there were systems in place for undertaking, recording, and monitoring all aspects of staff supervision, appraisal, and ongoing professional development.

Evidence was available that staff who have professional registration undertake continuing professional development (CPD) in accordance with their professional body's recommendations.

It was demonstrated that staffing levels are safe and staff are appropriately trained to meet the needs of patients.

4.2.4 How does the service ensure that recruitment and selection procedures are safe?

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

Recruitment and selection policies and procedures were in place and available for review. However, the recruitment policy did not include all of the necessary pre-employment checks to be undertaken prior to new staff commencing work in the establishment in line with legislation.

Discussion with Ms Waring and the clinic manager identified that two new staff members had been appointed to work as part of the minor day surgery service. A review of the two new staff member's personnel files identified that not all information as listed in Regulation 19, Schedule 2 of The Independent Health Care Regulations (NI) 2005 had been sought and retained. Ms Waring was advised to ensure that all recruitment documentation as outlined in Schedule 2 of The Independent Health Care Regulations (NI) 2005 is sought and retained for any new staff members recruited in the future. The recruitment policy should be updated to fully reflect the legislative requirements. An area for improvement against the Regulations has been made in this regard.

A review of the staff register document identified it did not contain details of the staff currently working in Face Therapy NI Ltd. An up-to-date staff register, containing the necessary information as detailed in Schedule 3 Part II of the Independent Healthcare Regulations (NI) 2005, should be maintained and readily available for review. Ms Waring was reminded that the staff register is a live document and should be updated and amended as required. An area for improvement against the Regulations has been made in this regard.

Evidence was not available that an enhanced AccessNI disclosure check had been undertaken prior to commencement of employment in respect of one staff member. An area for improvement has been made in this regard.

Addressing the areas for improvement will ensure that recruitment complies with the legislation and best practice guidance to ensure suitably skilled and qualified staff work in the clinic.

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

Ms Waring confirmed that minor day surgical procedures will not be provided to persons under the age of 18 years.

The arrangements for managing safeguarding issues affecting vulnerable adults at risk of harm did not form part of this inspection and will be reviewed at the next on-site variation to registration inspection.

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

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.

There was a medical emergency policy and procedure in place. A review of this found that it was not comprehensive and required further development.

It was identified the staff member recorded in the policy with responsibility for checking the emergency medicines no longer worked in the establishment. This was discussed with Ms Waring who agreed to address this matter.

An emergency trolley was located outside both treatment rooms. A review of the contents confirmed that sufficient emergency medicines and equipment were not retained in line with resuscitation guidance. This was discussed with Ms Waring who agreed to address this matter. Systems in place to ensure that emergency medicines and equipment do not exceed their expiry date required further development. An area for improvement has been made in this regard. Addressing this area for improvement will ensure that safe arrangements are in place to ensure the hospital is equipped to manage a medical emergency should this occur.

Managing medical emergencies is included in all staff member's induction programme and training will be updated annually. The records reviewed verified that all staff members had completed medical emergency training in keeping with best practice guidance.

Ms Waring was satisfied that the clinical team are knowledgeable of the action to take in the event of a medical emergency, and that they are familiar with the location of medical emergency medicines and equipment.

It was confirmed by Ms Waring that patients will recover in the treatment room and consultation area and be supervised should a patient require medical attention.

4.2.7 Medicine management

The arrangements for medicines management were discussed with Ms Waring and the clinical lead.

Ms Waring advised that the only medicines held, in addition to those retained in the emergency trolley, are local anaesthetic and sodium chloride solution for administration during procedures.

Advice was provided to Ms Waring to develop and maintain a medicines management policy, documenting arrangements for the ordering, storage, administration and disposal of medicines, including record keeping. Advice was also provided in relation to regularly auditing the management of medicines.

Ms Waring advised any medicines administered to the patient prior to their discharge will be recorded in the patient's clinical record and will include batch numbers and the expiry date of the medicine. Medicines required on discharge following any procedures are prescribed by the medical practitioner who provides a prescription to the patient.

It was demonstrated that patients will be provided with clear details on administering their medicines and are provided with contact details for post-operative support.

4.2.8 How does the service ensure that it adheres to infection prevention and control and decontamination procedures in keeping with best practice guidance?

The arrangements for IPC procedures concerning the proposed minor surgical procedures were reviewed to evidence that the risk of infection transmission to patients, visitors and staff was minimised.

A range of IPC policies and procedures were in place. A review of these documents evidenced that they required further adaptation to the day surgery setting and clinical environment in line with best practice guidance. Information such as treatment room cleaning schedules and actions to take in the event of potential minor blood spillages were not documented in any of the IPC documentation reviewed. During the feedback meeting held in RQIA head office on 18 April 2025, Face Therapy NI Ltd were requested to appoint an external IPC consultant to advise on IPC requirements for the minor day surgical procedures proposed. An area for improvement against the standards has been made in this regard.

A tour of the extension was undertaken and all areas were found to be clean, tidy, uncluttered and finished to a high standard of décor. Face Therapy NI Ltd has two dedicated treatment rooms for surgical day procedures, a consultation room, disabled access toilet and reception area. Advice and guidance was provided to Ms Waring regards the provision of hand sanitiser facilities in non-treatment areas.

Clinical areas had hand washing sinks, mounted soap and hand towels dispensers, and hand hygiene posters displayed at each hand hygiene area. Personal protective equipment (PPE) was readily available in keeping with best practice guidance.

It was confirmed that only two surgery patients will be booked in and treated on procedure days, with each patient having their own treatment room. Ms Waring confirmed that on procedure mornings, the lead nurse will be responsible for preparing the treatment room, cleaning down the couch, work surfaces and all equipment. It was confirmed that a new treatment couch was in place in each room and both have wipe-able coverings. All equipment will be cleaned after use, once the patient has vacated the treatment room and been discharged by the doctor.

Advice was provided to Ms Waring and the clinic manager to develop cleaning schedules and a daily check list for completion by the lead nurse. Ms Waring was receptive to this advice and agreed to implement this moving forward. A colour coded cleaning system was in place to minimise the risk of cross-contamination.

Waste management arrangements were established, clinical waste bins were pedal operated in keeping with best practice guidance and sharps containers were wall mounted, signed and dated on assembly.

Arrangements regarding the decontamination of equipment and reusable medical devices were discussed with Ms Waring, who confirmed that only single use equipment will be used. Advice was provided to Ms Waring to review protocols which make reference to the reprocessing of surgical instruments and to amend these to accurately reflect the use of single use equipment. As previously discussed staff training records confirmed that staff have completed IPC training commensurate with their roles and responsibilities.

Addressing the area for improvement will ensure that arrangements are in place to ensure that the service adheres to infection prevention and control and decontamination best practice guidance.

4.2.9 Are there safe practices in place for the day surgery service?

We reviewed the arrangements for the provision of day surgery and all related documentation.

Discussion with Ms Waring and review of documentation confirmed that prospective patients will have an initial consultation with the medical practitioner who undertakes the procedure.

At this face to face appointment, patients will have an in-depth consultation and assessment and also be provided with information and advice. It will be made clear to the prospective patients the content of both consultation options and the associated consultation fees. Patients are given adequate time to consider options.

We were informed that the medical practitioner performing the minor surgical procedure is responsible for gaining consent from patients for their care and treatment in line with legislation and guidance.

The scheduling of patients for minor day surgery procedures will be co-ordinated through the Face Therapy NI Ltd administration team. Scheduling will take into account individual patient requirements, staffing levels, the estimated length of the procedure and any associated risks.

The inspection team were informed that the medical practitioner and lead nurse will complete a surgical safety checklist based on World Health Organisation (WHO) guidance. Advice was provided to Ms Waring to ensure a register is maintained of all surgical operations performed and which details are to be included in line with the regulations. Ms Waring gave assurances that this matter would be addressed. Compliance audits relating to completion of the surgical checklist and patient registers will be undertaken by the lead nurse.

Clinical protocols are in place for all proposed surgical procedures offered at Face Therapy NI Ltd. Review of these protocols confirmed that they outlined patient selection, clinical and practice environment, the procedure, the recording of the procedure and patient follow up. Ms Waring was advised to ensure that all clinical protocols are signed by a registered medical practitioner(s) who is appropriately trained and experienced in the relevant discipline in which the treatment is provided. Ms Waring agreed to address this matter.

Discussion with Ms Waring confirmed that patients will receive local anaesthesia only. It was confirmed that no other form of sedation would be required. Following our advice and guidance, Ms Waring agreed to review the clinical protocols to ensure any current arrangements in relation to anaesthesia were accurately reflected in the protocols.

It was confirmed that patients will be observed during and after the procedure by the clinical team. Patients will be discharged in accordance to discharge criteria by the medical practitioner who undertook the procedure. Patients will be provided with clear post procedure advice, information on follow up and who to contact in the event of a post treatment emergency.

4.2.10 How does the service ensure patient records are managed in line with best practice?

Face Therapy NI Ltd is registered with the Information Commissioners Office (ICO). There is a range of policies and procedures in place for the management of records and clinical record keeping. It was confirmed that all patient's clinical records are held electronically and this will enable Face Therapy NI Ltd to have oversight in this regard.

Staff were able to describe the arrangements in place for effective records management and displayed an awareness of the need to comply with the General Data Protection Regulations (GDPR) 2018.

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

As the provision of minor day surgical services had not yet commenced Ms Waring outlined the patient's pathway and demonstrated how the associated clinical records will be completed from the point of the initial consultation with the patient through to discharge.

The electronic patient records system will be used to store the following; the patients details, records of consultations, photographs of the treatment area, signed consent agreement, pre-operative notes, the surgical plan, operation notes to include a record any local anaesthesia that had been given to the patient, and notes on the patient's post-operative care and medicine regime.

Patients are provided with written information on the specific procedure that will be undertaken which explains the risks, complications and expected outcomes of the treatment. Patients will also be provided with clear post-operative instructions along with contact details if they experience any concerns.

It was determined that appropriate arrangements were in place to ensure patients have a treatment plan and have sufficient information to consent to treatment.

4.2.11 Is the premises fit for the purpose of providing safe and effective care?

A tour of the new facility confirmed that the environment was maintained to a high standard of maintenance and décor and suitable arrangements were in place for maintaining the environment.

As discussed in Section 2.0 of this report an RQIA estates support officer, undertook a desktop review of the premises section of the registration application and following this inspection approved the variation to registration application from an estates perspective.

4.2.12 Are robust arrangements in place regarding clinical and organisational governance?

The policies and procedures surrounding clinical and organisational governance arrangements were reviewed and discussed with Ms Waring.

It was demonstrated that there was a clear management structure with defined lines of responsibility and accountability for the different services provided at the establishment.

Ms Waring and the clinic manager are supported by an external medical practitioner on medical matters relating to the minor day surgery service. The lead nurse for day surgery acts as the compliance officer and audit lead for the service.

Policies and standard operating procedures were in place to support practice, however they required to be localised to the establishment and the procedures offered as part of the day surgery service. Ms Waring agreed to action this matter.

Ms Waring described the governance structure at Face Therapy NI Ltd and demonstrated how there are processes and systems of accountability in place to support the delivery of good quality services and to monitor and maintain high standards of care.

A formal clinical governance meeting takes place quarterly between Ms Waring, the clinic manager and the compliance officer. Patient feedback will be sought and reported bi-annually.

A medical advisory committee (MAC) has been established which will meet quarterly. The quorum for the MAC consists of Ms Waring, the clinic manager and an external medical practitioner. Standing agenda items were recorded and will include responsibility for surgeon performance and surgery specific matters, audit and risk management, operational and administrative issues, significant incidents and themes reported. The clinic manager will responsible for taking minutes and producing reports.

Practising Privileges

As previously discussed, there is currently only one private doctor appointed to undertake day surgery procedures.

It was confirmed that the private doctor has completed specialist training in the procedures to be provided by Face Therapy NI Ltd.

Ms Waring confirmed that she is aware that 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.

A policy and procedural guidance for the granting, review and withdrawal of practicing privileges agreements was in place. Ms Waring confirmed that any applications will be reviewed by herself, as the clinical director, in conjunction with the medical director of Face Therapy NI Ltd.

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 (NI) 2005, as amended. Ms Waring confirmed that practising privileges agreements will be reviewed annually in the first instance.

A stated previously, a review of relevant documentation evidenced that a signed practising privileges agreement, reflecting the scope of practice of the current private doctor, was not available for inspection. An area for improvement is made against the standards in this regard.

Addressing the area for improvement will ensure there is adequate 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.

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

Notifiable Events/Incidents

A policy for the management and reporting of clinical risks, incidents and near misses and a policy for the management of national safety alerts were in place. Ms Waring 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 will be discussed at the organisation's clinical governance meetings and medical advisory committee.

Complaints Management

A copy of the complaints procedure was available in the hospital and was found to be in line with the relevant legislation and the Department of Health (DoH) guidance on complaints handling.

Ms Waring confirmed that a copy of the complaints procedure is made available for patients/and or their representatives on request and demonstrated a good awareness of complaints management.

It was confirmed that complaints received will 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. Ms Waring confirmed that information gathered from complaints will be used to improve the quality of services provided.

Overall, the governance structures within the hospital provided the required level of assurance to the management team and the MAC.

5.2.13 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 Waring and the clinic manager.

Discussion and review of information evidenced that the equality data collected will be managed in line with best practice.

6.0 Quality Improvement Plan/Areas for Improvement

Six areas for improvement have been identified where action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and Minimum Care Standards for Independent Healthcare 2014

	Regulations	Standards
Total number of Areas for Improvement	3	4*

*the total number of areas for improvement includes one which has been carried forward for review at the next inspection.

Areas for improvement and details of the QIP were discussed with Ms Waring, Responsible Individual, and the clinic manager as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 19 (2) Schedule 2, as amended **Stated:** First	The registered person shall ensure that all recruitment documentation as outlined in Schedule 2 of The Independent Health Care Regulations (NI) 2005, as amended is sought and retained for all staff. Ref: 4.2.4
To be completed by: Ongoing from the date of inspection	**Response by registered person detailing the actions taken:** In compliance with Regulation 19 and Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended, we have taken a series of actions to ensure that all required recruitment documentation is sought and retained for all staff working in the clinic. Firstly, our recruitment policy has been updated to reflect the specific requirements outlined in Schedule 2. Staff involved in recruitment, are fully aware of the necessary pre-employment checks and documentation standards. To support consistency, we have introduced a standardised recruitment checklist. This checklist ensures that key documents such as proof of identity, references, full employment history, relevant qualifications, health declarations, AccessNI checks, and evidence of the right to work in the UK are collected and verified for every new employee. To maintain oversight, annual audits of staff recruitment files are now carried out. These audits help ensure that all required documentation is present and compliant. Any discrepancies identified are promptly addressed. All recruitment records are securely stored electronically in a restricted-access system. This not only protects personal data but also ensures that important documents are not lost or misplaced. We retain all records in accordance with our data protection policy and the regulatory guidance on document retention.
Area for improvement 2 **Ref:** Regulation 21 (3) Schedule 3, as amended **Stated:** First time	The registered person shall ensure that an accurate and up to date staff register is maintained and includes the details as outlined in Schedule 3, Part II of the Independent Healthcare Regulations (NI) 2005. Ref: 4.2.4
To be completed by:	**Response by registered person detailing the actions taken**:

Ongoing from the date of inspection	In accordance with Schedule 3, Part II of The Independent Health Care Regulations (Northern Ireland) 2005, the registered person has taken the necessary steps to ensure that an accurate and up-to-date staff register is maintained. This register includes all required details such as the full name, address, date of birth, qualifications, position held, and the dates of commencement and, where applicable, termination of employment for each member of staff. The staff register is now maintained electronically in a secure, centralised HR system with restricted access, ensuring data integrity and confidentiality. Regular quarterly eviews are carried out by the responsible person to verify the accuracy and completeness of the register, and any updates (e.g., changes in staff roles, qualifications, or personal information) are recorded promptly.
Area for improvement 3 **Ref:** Regulation 19 (2) Schedule 2, as amended **Stated:** First time **To be completed by:** Ongoing from the date of inspection	The registered person shall ensure that an AccessNI enhanced disclosure check is completed and the outcome recorded prior to staff members commencing employment. Ref: 4.2.4
	Response by registered person detailing the actions taken: Each staff member employed within the service has undergone an AccessNI check prior to commencing employment, in line with our safer recruitment policy and the requirements of The Independent Health Care Regulations (NI) 2005. These checks are used to assess suitability for working in regulated healthcare settings and are retained on file as part of each employee's recruitment documentation.
Action required to ensure compliance with the Minimum Care Standards for Independent Healthcare 2014	
Area for Improvement 1 **Ref:** Standard 48.21 **Stated:** First time **To be completed by:** 16 September 2024	The responsible individual shall ensure that the Laser Protection Supervisor (LPS) regularly reviews the laser safety file, to ensure that it is accurate, up to date and contains all of the relevant information in relation to laser and intense light equipment.
	Action to ensure compliance with this area for improvement was not reviewed during this inspection and has been carried forward for review at the next inspection.
Area for improvement 2 **Ref:** Standard 11 **Stated:** First time	The responsible person shall ensure that a written agreement between the practitioner and the establishment is retained for inspection and that it sets out the terms and conditions of granting practising privileges and defines the specialty or specialties in which the practitioner may treat patients and clients.

To be completed by: Ongoing from the date of inspection	Ref: 4.2.4 & 4.2.12
	Response by registered person detailing the actions taken: The registered person ensures that a written agreement is maintained between each independent practitioner and the clinic in accordance with RQIA standards and the requirements set out in The Independent Health Care Regulations (Northern Ireland) 2005. This agreement formally sets out the terms and conditions under which the practitioner is granted practising privileges within our clinic. Prior to the commencement of any clinical activity, the practitioner is required to sign a written agreement which includes, but is not limited to: scope of practice, professional indemnity requirements, arrangements for clinical governance and audit participation, ongoing training and appraisal, responsibilities relating to record keeping, infection prevention and control, and the duty to comply with the clinic's policies and regulatory standards. The granting of practising privileges is subject to a structured approval process, including verification of qualifications, references, professional registration, and AccessNI or DBS clearance. Practising privileges are reviewed on an annual basis or sooner if there are any concerns, with any changes documented and confirmed through a renewed written agreement. All agreements are stored securely and monitored as part of the clinic's governance processes. The maintenance of these agreements ensures clarity, accountability, and alignment with RQIA's Independent Healthcare Provider Minimum Standards. particularly Standard 1.8, which states that practising privileges must be granted through a formal agreement and regularly reviewed. Through this process, we are able to demonstrates our commitment to high standards of clinical governance and regulatory compliance.
Area for improvement 3 **Ref:** Standard 18 **Stated:** First time **To be completed by:**	The responsible person shall ensure that emergency resuscitation equipment is retained in line with resuscitation guidance; is readily accessible to staff; and monitored by a nominated staff member. Medical emergency policies and procedures should be in place and regularly reviewed. Ref: 4.2.6

Ongoing from the date of inspection	**Response by registered person detailing the actions taken:** The registered person has implemented a range of measures to ensure that emergency resuscitation equipment is retained, readily available, and maintained in accordance with Resuscitation Council (UK) guidelines and RQIA regulatory requirements. A designated, appropriately trained staff member has been assigned responsibility for the weekly checking and documentation of all emergency equipment, including the automated external defibrillator (AED), and emergency medications. This is recorded on a log sheet that is reviewed monthly to ensure accountability and audit readiness. Emergency resuscitation equipment is stored in a clearly labelled and located on the ground floor at the front of the medical reception desk on the crash trolley. It is regularly inspected for functionality, expiry dates, and completeness of contents. In addition, a comprehensive inventory of the resuscitation kit is maintained and updated in line with any changes to national guidance or clinic-specific risk assessments. The clinic has a robust Medical Emergency Policy and Procedure, which outlines staff responsibilities, emergency response protocols, training requirements, and communication pathways in the event of a medical emergency. This policy is reviewed every two years, or immediately following any incident, equipment update, or changes to national resuscitation guidelines. All relevant staff undergo annual Basic Life Support (BLS), with training records maintained on file. Emergency drills are conducted periodically to ensure staff confidence and familiarity with their roles during critical incidents. These measures collectively ensure that the clinic is well-prepared to manage medical emergencies promptly and effectively, maintaining patient and staff safety in accordance with best practice standards.
Area for improvement 4 **Ref:** Standard 20 **Stated:** First time **To be completed by:** Ongoing from the date of inspection	The responsible person shall ensure that there are IPC policies and procedures in place that are applicable to the day surgery environment and in line with regional infection control guidelines. An external IPC consultant should be appointed to advise on IPC requirements for the minor day surgical procedures proposed. Ref: 4.2.8
	Response by registered person detailing the actions taken:

	The registered person has taken comprehensive steps to ensure that Infection Prevention and Control (IPC) policies and procedures are in place, specific to the day surgery environment, and fully aligned with regional infection control guidelines and best practice standards. To strengthen our IPC framework, we engaged an external IPC consultant, who attended the clinic on 9th May to carry out a full infection control risk audit and assessment. This assessment focused on identifying potential risks associated with surgical procedures in the day surgery setting, including environmental hygiene, aseptic technique, staff compliance, and sterilisation and decontamination protocols. Following this assessment, the IPC Consultant will provide the clinic with customised IPC procedures tailored to surgical interventions, ensuring that all practices reflect current regional and national guidance. These procedures will be formally incorporated into our IPC policy, and staff will be briefed and trained accordingly. In the interim, the clinic is operating under existing IPC protocols, which have been reviewed to confirm that they remain consistent with the Northern Ireland Regional Infection Prevention and Control Manual. These include procedures for hand hygiene, personal protective equipment (PPE), environmental cleaning, waste management, and safe handling of surgical instruments. Our IPC policies are subject to regular reviews or sooner if updated guidance is issued or following any incident or audit finding. Staff receive regular IPC training and updates, and compliance is monitored through internal audits and supervision.

Please ensure this document is completed in full and returned via Web Portal

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