The Regulation and Quality Improvement Authority

Inspection Report

16 & 17 July 2025

Kingsbridge Diagnostic and Treatment Centre

Type of service: Independent Hospital (IH) – Day surgery services, Endoscopy services (day cases only), Private Doctor, Cosmetic Laser and Refractive Eye Laser service

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Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Kingsbridge Healthcare Group Limited **Responsible Individual:** Mr Mark Regan	**Registered Manager:** Mrs Ashling Green **Date registered:** 11 April 2024
Person in charge at the time of inspection: Mrs Ashling Green	
Categories of care: (IH) Independent Hospital AH(DS) - Acute Hospital (Day Surgery) PD - Private Doctor PT(E) – Endoscopy PT(L)- Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers	
Brief description of how the service operates: Kingsbridge Diagnostic and Treatment Centre (KDTC) is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital with acute hospitals (day surgery only) AH(DS); prescribed techniques or prescribed technology: establishments providing endoscopy services PT(E); laser services PT(L) and private doctor (PD) categories of care. Kingsbridge Diagnostic and Treatment Centre (KDTC) provides a wide range of outpatient services and treatment that do not require general anaesthesia; this covers a range of medical specialties, diagnostic tests and investigations including endoscopy services, surgical day case procedures, lens surgery and laser eye procedures. Kingsbridge Healthcare Group Limited is the registered provider for three independent hospitals registered with RQIA. Mr Mark Regan is the responsible individual for Kingsbridge Healthcare Group Limited **Laser equipment available in the service:** Manufacturer: Lumenis Model: Aura Yag PT Serial Number: YA44-0165 Laser Class: 3B Wavelength: 1064nm	

Manufacturer: Zeiss
Model: Visumax 800
Serial Number: 9511100388
Laser Class: 3B
Wavelength: 1043nm

Manufacturer: Zeiss
Model: Mel 90
Serial Number: 9507700033
Laser Class: 4
Wavelength: 193nm

Types of laser treatment provided:
Refractive eye surgery – Lasik, Smile, Photorefractive keratectomy **(**PRK)
Capsulotomy procedures using Lumenis - Aura Yag.

2.0 Inspection summary

A short notice announced inspection was undertaken to the Kingsbridge Diagnostic and Treatment Centre (KDTC) on 16 and 17 July 2025 by a senior care inspector, two care inspectors and an ADEPT (Achieve Develop Explore Programme for Trainees) Fellow.

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

RQIA's Laser Protection Advisor (LPA) attended the inspection on 16 July 2025 and reviewed the laser equipment and the laser safety arrangements. Their report containing their findings and recommendations is appended to this report. Following this inspection, RQIA received evidence which confirmed that all recommendations identified by RQIA's LPA have been actioned. Further detail is provided in section 5.2.5 of this report.

Feedback of the onsite inspection findings was delivered to Mrs Green, registered manager; the clinical governance manager, Kingsbridge Healthcare Group; and the lead ophthalmology nurse at the conclusion of the inspection on 17 July 2025.

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

Examples of good practice were evidenced in respect of the oversight mechanisms in place to provide assurances relating to clinical governance, the management of the patients' care pathway and engagement between teams to enhance the patients' experience of care.

No concerns were identified in relation to patient safety.

3.0 How we inspect

RQIA is required to inspect registered services in accordance with legislation. To do this, we gather and review the information we hold about the service, examine a variety of relevant records, meet and talk with staff and management and observe practices on the day of the inspection.

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

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

One week prior to the onsite inspection the hospital was provided with a list of specific documents requesting items to be reviewed at the onsite inspection.

During the inspection we spoke with the registered manager, the compliance manager for Kingsbridge Healthcare Group, the lead endoscopy nurse, the project lead for Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation, the day procedure unit manager, the lead ophthalmology nurse and the deputy manager for decontamination.

During the onsite inspection the team undertook a tour of the premises. The inspection was facilitated by Mrs Green, registered manager.

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).

4.0 What people told us about the service?

We issued posters to the registered provider prior to the inspection inviting patients and members of staff to complete an electronic questionnaire.

Nine staff submitted questionnaire responses. Staff responses indicated that they felt patient care was safe, effective, that they were treated with compassion and that the service was well led. Staff indicated that they were satisfied or very satisfied with each of these areas of patient care. Seven comments were received, which spoke positively of management, teamwork and the service provided to patients.

Through discussion with a number of staff who have roles and responsibilities, it was determined that staffing levels and morale were good, with evidence of good multidisciplinary team working and effective communication between staff.

5.0 The inspection

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

The last inspection to KDTC was undertaken on 25 July 2024; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Governance and Leadership

Organisational governance

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

As previously outlined, Mr Regan is the responsible individual and Mrs Green is the registered manager.

Where the business entity operating a registered establishment is a corporate body or partnership or an individual owner who is not in day to day management of the service, unannounced quality monitoring visits by the registered provider, or person acting on their behalf, must be undertaken and documented every six months; as required by Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005.

As previously stated, Mr Mark Regan is the responsible individual for Kingsbridge Healthcare Group Limited which has three independent hospitals registered with RQIA. Mrs Green, as registered manager, is the nominated individual with overall responsibility for the day to day management of KDTC. Mrs Green confirmed that she has regular contact with Mr Regan who frequently visits the establishment. It was agreed that the arrangements for undertaking six monthly unannounced monitoring visits, in accordance with legislative requirements, will be followed up with Mr Regan separately.

KDTC is part of the Kingsbridge Healthcare Group and is supported by well-established governance arrangements. This includes a range of meetings attended by representatives from the senior management team, hospital managers and clinical leads.

The organisational and governance structure is built around the governance and compliance strategy framework. This framework is made up of seven quality pillars including; information and IT, audit, clinical effectiveness, patient involvement, staff management, education and training and risk management. The organisational structure defines and specifies roles and responsibilities with clear lines of accountability for each areas of activity.

Members of the KDTC management team spoken with described an effective governance structure, which provides a process and system of accountability to support the delivery of good quality service and to monitor and maintain high standards of care.

Governance and quality teams are organised at local and group administration level. The local team meet monthly and report directly to the team at Group level which meets quarterly. The Group administration governance and quality team collate an annual quality report for board level. It was good to note that a Group head of corporate governance and a Group clinical governance manager were recently appointed. Separate quality and governance teams are in place for compliance and risk, IT, infection prevention and control (IPC), and estates.

The local management team at KDTC meet on a weekly basis with heads of department.

It was good to note that department and specialism meetings are held regularly and all relevant staff are required to attend. Minutes of the endoscopy user group meeting were retained. Review of the minutes evidenced that the meeting serves as a forum for open discussion and sharing staff concerns.

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

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

Clinical and medical governance

A team of consultants who have specialist qualifications and skills in endoscopy and minor surgery work in KDTC. In addition, private GP services are currently available on an appointment only basis.

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 KDTC is registered with the GMC as a designated body and have an appointed RO.

There was a medical advisory committee (MAC) which meet quarterly with responsibility for consultant and surgery specific matters.

It was noted in conversation with Mrs Green that an online portal has been available to medical practitioners since spring of 2025. The portal should strengthen current systems, allowing the medical director and MAC to have an accurate and up to date positional status on all individual consultants' medical appraisals.

Medical practitioners working in the Kingsbridge Healthcare Group are now able to submit appraisal documentation and competency declarations via the portal. Medical practitioners will receive automated reminders for any expiring documents. Recent minutes of the MAC detailed that the revalidation of medical practitioners was up to date and that the deadline for uploading 2024 appraisals was 30 September 2025.

A small number of medical practitioners 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.

A review of four private doctors' details demonstrated 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

It was noted however, that evidence of arrangements for revalidation were either out of date or not documented in respect of some consultants. This was brought to the attention of Mrs Green and the group compliance manager who agreed to address this matter.

All consultants who work in KDTC are not directly employed by the establishment and work under a practising privileges agreement. We spoke with Mrs Green about the arrangements for the oversight and recording of on-going training for consultants to ensure they receive mandatory training and other relevant training, in accordance with the legislation, minimum standards and regional policies.

Consultant training days are held periodically through the year and consultants/clinicians are encouraged to avail of this opportunity to keep mandatory training up to date. Records are retained to evidence the date of attendance of consultants and private GPs at these mandatory training days.

A staff training policy, defining statutory and mandatory training required by the Kingsbridge Healthcare Group based on roles and responsibilities, was reviewed. Staff in this instance refers to individuals directly employed and those individuals who have been granted practising privileges agreements.

We advised Mrs Green that the Kingsbridge Healthcare Group should define what it requires by way of mandatory training for all employees and medical practitioners with practicing privileges, and what is specific to specialised roles. It is therefore for the establishment to set out, within its own policy, the training requirements for individual staff groups and the frequency and methods of training. Training records must be retained for all topics as specified within the policy.

Consideration should be given to legislation, minimum standards and regional policies when identifying mandatory training topics.

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.

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 procedure for the granting, review and withdrawal of practicing privileges agreements was not available for review at the time of inspection. Mrs Green advised that this document is undergoing revision and had not yet been ratified by the MAC.

A review of a sample of records evidenced that there was a written practicing privileges agreement between each private doctor and KDTC, which set out the terms and conditions.

Review of minutes demonstrated that practicing privileges matters, including the withdrawal of privileges, are discussed and reviewed during MAC meetings.

It was noted that the practising privileges agreements had been reviewed within the previous two years, clearly stating each private doctor's scope of practice and had been signed by both the doctor and the medical director of the Kingsbridge Healthcare Group.

As previously stated, an electronic portal system for medical practitioners with practising privileges went live in the spring of 2025. This tracking system will retain the necessary evidence for continued practicing privileges to be granted by the MAC.

Good oversight arrangements of the granting of practicing privileges agreements were in place and provided assurance of robust medical governance arrangements within the organisation.

Quality assurance

Arrangements were in place to monitor, audit and review the effectiveness and quality of care and treatment delivered to patients at appropriate intervals.

Significant incidents and themes reported are discussed at the organisation's clinical governance and meetings, medical advisory and health and safety committees.

There was a robust programme for internal audit to monitor compliance with policies and processes. Audits are completed monthly, quarterly and annually as per the KDTC audit schedule. The results are monitored by the local and regional management team and actions identified for improvement are embedded into practice. If required, an action plan is developed to address any shortfalls identified during the audit process.

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

Notifiable Events/Incidents

A policy for the management and reporting of clinical risks, incidents and near misses and a policy for the management of national safety alerts were in place.

Mrs Green confirmed that any learning from incidents would be discussed with staff. There was a process in place for analysing incidents and events to detect potential or actual trends or weakness in a particular area in order that a prompt and effective response can be considered at the earliest opportunity.

As previously mentioned significant incidents and themes reported are discussed at the organisation's clinical governance meetings and medical advisory and health and safety committees.

Complaints Management

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

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

A review of the complaints log confirmed that all complaints received 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. The management of complaints is reviewed on a weekly basis with an over-arching quarterly audit of complaints undertaken to identify trends or themes emerging. The quarterly audit of complaints is included as standing agenda item for the MAC meetings.

It was demonstrated 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 responsible individual and the Kingsbridge Healthcare Group.

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

Staffing arrangements were reviewed and it was confirmed that appropriately skilled and qualified staff were in place in respect of the services offered.

Mrs Green confirmed that same day surgery services, such as cataract surgery, had been relocated from Kingsbridge Private Hospital and that staff had either been relocated or recruited since the previous RQIA inspection to support clinical operations.

Mrs Green demonstrated that staff training is managed through the Kingsbridge Healthcare Group's training academy and also consultant mandatory training days held throughout the year. All staff are facilitated and encouraged to take part in ongoing training to update their knowledge and skills, relevant to their role.

Consultants working under practicing privileges are expected to submit evidence of their mandatory training. A review of a sample of three consultant training files evidenced that they had completed and retained evidence of mandatory training.

An electronic matrix provides Mrs Green with oversight of mandatory training compliance for staff directly employed by the clinic. A review of the most recent summary report of compliance demonstrated that staff had either completed or were in the process of completing training as outlined in the RQIA training guidance and legislation.

Staff we spoke to stated there were opportunities to undertake additional training in relation to their work and there was evidence that these matters were discussed and agreed during supervision and appraisal.

Induction programmes relevant to roles and responsibilities are required to be completed when new staff join the team. A review of records confirmed that the newly appointed staff had complete a structured induction and orientation.

Discussion with Ms Green 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.

It was determined that appropriate staffing levels were in place to meet the needs of patients and the staff were suitable trained to carry out their duties.

5.2.3 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.

KDTC has a corporate human resources (HR) shared services department. The corporate HR department supports Mrs Green during the recruitment process. Mrs Green confirmed that she has access to the electronic HR system and can verify that all required recruitment documentation is in place for new staff members prior to their commencement of work.

A recruitment policy and procedure was in place which was in keeping with legislation and best practice guidance.

A number of new staff had been recruited since the previous inspection to support service development. A review of a sample of personnel files of staff recruited, confirmed that in the main, recruitment documentation, as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005, had been sought and retained. A discussion took place regarding the provision of criminal conviction declaration for medical practitioner applicants. This will be followed up with Mr Regan following the inspection.

Discussions with Mrs Green confirmed she had a clear understanding of recruitment and selection legislation and best practice guidance.

It was determined that recruitment and selection procedures were in place to ensure compliance with the legislation and best practice guidance.

5.2.4 Are there safe practices in place for the day surgery and endoscopy services?

We reviewed the arrangements for the provision of day surgery and endoscopy services in the hospital outlined under their statement of purpose and categories of care. The review of day surgery and endoscopy arrangements evidenced that the service will operate in accordance with best practice and national standards to ensure care delivery is safe and effective.

The scheduling of patients for day surgery or endoscopy procedures will be co-ordinated by Kingsbridge Healthcare Group booking system with the involvement of senior nursing staff. Scheduling will take into account individual patient requirements, staffing levels, the nature of the procedure and any associated risks.

The patient will be sent information about the procedure and any preparation necessary in advance, together with the consent form.

The consent process is completed by the consultant carrying out the procedure as part of the admission process. The consented patient is then escorted to the treatment room or endoscopy suite. It was noted that a number of consent forms had been completed in blue ink. It was advised that best practice is to complete consent forms in black ink. Management were receptive to this advice.

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

It was confirmed that patients are observed during and after the procedure by appropriately trained staff. Patients are discharged in accordance to discharge criteria by the nursing staff. It was confirmed that if there were any concerns about the patient's condition, the consultant would be immediately informed for ongoing management. Patients are provided with clear, post procedure advice information on follow up, and who to contact in the event of a post treatment emergency.

Surgical registers are maintained for all procedures undertaken in the hospital. It was advised to ensure the full name of staff nurses involved in the surgery or endoscopy procedures is recorded in the surgical registers.

Six completed patient records relating to day surgery patient care pathways, endoscopy patient care pathways and ophthalmology patient care pathways were reviewed and found to provide a framework for the clear record of admission, medical history, consent, IPC status, medication, observations on admission, pre-procedure checklist, surgical safety checklist (WHO), intra-procedure details, traceability details, post procedure observations and discharge record.

Medical emergencies were discussed with surgical staff including the management of a massive blood loss emergency. Staff confirmed that the range of surgical and endoscopy procedures currently carried out would be low risk in relation to a massive blood loss emergency. Advice was provided to give consideration to devising a massive blood loss procedure and implement a massive blood loss tray. Following the inspection, RQIA were informed that the medical director for Kingsbridge Healthcare Group had been consulted and a determination was made, given the nature and scope of surgical procedures performed at KDTC, the introduction of a separate massive blood loss tray would not add significant benefit in this setting at this time. It was stated that KDTC would review the need for additional measures, should the surgical service evolve in a way that increases the risk of significant blood loss.

Management and staff confirmed that a prevention of venous thromboembolism (VTE) assessment is carried out and preventive measures prescribed as necessary by the consultant surgeon.

There were two procedures for the collection, labelling, storage, preservation, transport and administration of specimens. It was noted that one of the procedures had exceeded the review date and it was confirmed this was not the current version. It was advised that only the current version of the procedure is available in line with robust version control measures and the previous version is taken out of circulation and archived. Staff clearly described detailed procedures for the management of specimens and the procedure for reporting results to the appropriate clinical staff and General Practitioners (GP) which was fully reflected in the current written procedure. It was confirmed there is a contract in place with a pathology laboratory service. The pathology services are subject to internal audit.

KDTC have an onsite endoscopy decontamination suite which has been operational since August 2023. The endoscopy decontamination process was clearly described by the deputy decontamination manager and the comprehensive electronic record of this pathway was reviewed. It was found to be well understood and completed by suitably qualified and trained staff. The decontamination process is subject to a rolling programme of robust audits including a weekly internal audit and a three monthly unannounced audit by the sterile services manager who based in the sterile services department within Kingsbridge Hospital North West.

It was determined that there were safe practices in place for the day surgery and endoscopy services.

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

The arrangements in respect of the management of medical emergencies were reviewed. KDTC has policies and procedures in place for dealing with 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.

It was confirmed that two emergency trollies are in place; one is located centrally on the ground floor and the other on the first floor ensuring that all staff have immediate access to appropriate drugs and equipment in the event of a medical emergency.

Systems were in place to ensure that emergency medicines and equipment do not exceed their expiry date. A check list was provided with each trolley that itemised both the contents of each drawer and the equipment stored on the top. An anti-tamper seal was in place.

The automated external defibrillator, oxygen cylinder and suction machine are checked daily. Pharmacy also conduct quarterly checks of controlled drugs.

It was identified that there was a means of calling for help in an emergency. This includes a nurse call button system for which there is an alarm display screen located at the nurses' station. This alarm is tested daily. There were also red desktop emergency telephones in place.

A review of training records evidenced that the consultant and all nursing staff had completed immediate life support (ILS) and all other staff for basic life support (BLS). A number of staff have advanced life support (ALS) and at least one member of staff with ALS is available in the hospital when patients are present.

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.

5.2.6 How does the service ensure that it adheres to infection prevention and control (IPC) and decontamination procedures?

The arrangements for IPC procedures throughout the hospital were reviewed to evidence that the risk of infection transmission to patients, visitors and staff was minimised. It was confirmed that a range of IPC policies and procedures were in place that were in keeping with best practice guidance and include outbreak management, notifiable diseases, transmission precautions, prevention, control and surveillance, and cleaning, disinfection and sterilisation.

A tour of the premises was undertaken and the hospital was found to be clean, tidy, uncluttered and finished to a high standard of décor. Staff described the arrangements to decontaminate the environment and equipment between patients in keeping with best practice.

It was confirmed that the majority of equipment used is single use where possible.

Cleaning schedules were in place and staff are advised on the appropriate disinfectant and cleaning process to use for equipment in between each patient usage.

As discussed previously endoscopes are decontaminated on site by appropriately trained and competent staff.

Kingsbridge Private Hospital North West (KPHNW) has an EN ISO 13485 certified Hospital Sterilisation and Decontamination Unit (HSDU) on site. This HSDU supplies sterile instrument packs for surgical procedures in KDTC. There are robust measures in place to monitor the traceability of all surgical instruments used in the hospital.

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 treatment rooms and consultation rooms provided dedicated hand washing facilities and hand sanitiser was available throughout the hospital.

It was confirmed that staff have access to an external IPC nurse consultant and each department has an IPC champion. There is also access to a microbiologist should advice be required and Public Health Agency (PHA) details available for staff.

It was confirmed that KDTC staff are part of the Kingsbridge Healthcare Group ‘Hospital Infection Control Steering Group’. There is a planned monitoring and measuring of IPC practices to reduce the risk of health care associated infections (HCAI). A review of records confirmed that a range of IPC audits are carried out and findings shared.

As previously discussed staff training records confirmed that staff have completed IPC training commensurate with their roles and responsibilities. It was confirmed that a training programme of Aseptic Non-Touch Technique (ANTT) has been developed and is currently being implemented for relevant staff.

The KDTC management and staff demonstrated good knowledge and understanding of IPC procedures.

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

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

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

A review of the laser safety files found that they contained all of the relevant information in relation to all the laser equipment in place. There was written confirmation of the appointment and duties of a certified LPA which will be reviewed on an annual basis. The service level agreement between KDTC and the LPA is due for renewal on 8 February 2026.

It was confirmed that refractive laser eye procedures are carried out by consultant ophthalmologists acting as the clinical authorised operators and are assisted by laser technicians acting as non-clinical authorised operators. A register of clinical and non-clinical authorised operators for the lasers is maintained and kept up to date.

Mrs Green confirmed that the consultant ophthalmologists undertake laser eye surgical procedures in accordance with medical treatment protocols produced by the medical directors of KDTC and systems were in place to review the medical treatment protocols on an annual basis. The treatment protocol for YAG capsulotomy contained the headings as outlined in standard 48.3 of the Minimum Care Standards for Independent Healthcare Establishments. We advised that the treatment protocol for iridectomy should be written in the same format. Following the inspection RQIA received a copy of the updated iridectomy treatment protocol that had been further developed as advised.

The clinic's LPA completed a risk assessment of the premises and the laser safety arrangements on 7 March 2025.

Up to date local rules were in place which have been developed by the LPA. The local rules contained the relevant information about the laser equipment being used and all appropriate authorised operators had signed to state that they had read and understood these.

Mrs Green confirmed that the LPS is aware that when the laser equipment is in use, the safety of all persons in the controlled area is their responsibility. Arrangements were in place for another authorised operator to deputise for the LPS, in her absence, who is suitably skilled to fulfil the role.

A review of training records confirmed that all clinical authorised operators had up to date training in core of knowledge; basic life support; infection prevention and control; fire safety awareness; and safeguarding adults at risk of harm in keeping with the RQIA training guidance.

It was evidenced that dedicated laser surgical and YAG registers are in place for all the laser equipment which include:

- the name of the person treated
- the date
- the operator

- the treatment given
- the precise exposure given
- any accidents or adverse incidents

The Zeiss laser suite and the Lumenis Aura PT YAG laser treatment room, known as controlled areas, were found to be safe and controlled to protect other persons while treatment is in progress. Mrs Green confirmed that the doors to the controlled areas are locked, when the laser equipment is in use and can be opened from the outside in the event of an emergency. It was noted that the controlled areas have an electronic locking system available with an associated emergency access procedure in place; there were also manual thumb turn locks on the doors. However, during discussion it was revealed that when the manual lock is used this voids the emergency access procedures. Advice was provided to review the access control procedures for the controlled areas and ensure that access is uninhibited in the event of an emergency. Following the inspection RQIA received a copy of the laser safety protocol which outlined the agreed actions to be taken to ensure the laser room cannot be accessed when the laser is in use and also ensures safe and immediate access 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.

Protective eyewear was available for non-clinical authorised operators if required. A review of the eyewear evidenced that it was provided as outlined by the LPA in the local rules.

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

Discussion with Mrs Green identified that arrangements have been established for the equipment to be serviced and maintained in line with the manufacturers' guidance.

Carbon dioxide (CO2) 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 the action taken by KDTC in response to advice provided during this inspection has strengthened the arrangements for the safe operation of the laser equipment.

5.2.8 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 the KDTC management team.

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

	Regulations	Standards
Total number of Areas for Improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Green, Registered Manager; the clinical governance manager, Kingsbridge Healthcare Group; and the lead ophthalmology nurse, as part of the inspection process and can be found in the main body of the report.

Appendix 1

Belfast Health and Social Care Trust
caring supporting improving together

28 July 2025

Laser Protection Report

Site Details

Kingsbridge Diagnostic and Treatment Centre
Kings Hall Life Science Park
Kings Hall
Upper Lisburn Road
Belfast
BT9 6TW

Laser Equipment:

Make	Model	Class	Serial Number	Wavelength
Lumenis	Aura PT	3B	YA44-0165	1064nm (Nd:YAG)
Zeiss	Visumax 800	3B	9511100388	1043nm
Zeiss	Mel 90	4	9507700033	193nm (ArF)

Introduction

A laser Protection Advisor inspection of Kingsbridge Diagnostic and Treatment Centre was performed on 16 July 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. Control of Access

The laser rooms has an electronic locking system available with associated emergency access procedure in place; there were also manual thumb turn locks on the doors. During discussions on the day of the inspection visit it was revealed that the manual lock were sometimes used; however this voids the current emergency access procedures. The clinic should review the access control procedures for the laser rooms and ensure that access is possible in event of an emergency. Following the review, the procedures should be communicated with relevant staff and any changes updated in the laser documentation.

2. Laser Treatment Protocols

The clinic should ensure the treatment protocols for YAG capsulotomy and iridectomy procedures 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. Treatment Registers

Whilst most records were correctly filled in, some records were not fully complete. The clinic should remind users of the importance of completing all fields in the laser register.

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

Laser Protection Advisor (LPA) to RQIA

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