Inspection Report

30 July 2025 & 31 July 2025

Jace Medical

Type of service: Independent Hospital – Day surgery cases only
Address: Units 1, 2, 9 & 10 The Vale Centre, Londonderry, BT47 3GE
Telephone number: 028 7116 5790

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/ The Independent Health Care Regulations (Northern Ireland) 2005 and Minimum Care Standards for Independent Healthcare Establishments (July 2014)

1.0 Service information

Organisation/Registered Provider: J.J.A.C.E. LTD **Responsible Individual:** Mr John Doherty	**Registered Manager:** Ms Delma McCurry **Date registered:** 25 November 2024
Person in charge at the time of inspection: Ms Delma McCurry	
Categories of care: Acute Hospital (Day Surgery) - AH(DS) Private Doctor - PD Endoscopy - PT(E)	
Brief description of how the service operates: Jace Medical is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital (IH) with prescribed techniques or prescribed technology: establishments providing endoscopy services PT (E); private doctor (PD) and acute hospitals (day surgery only) AH (DS) categories of care. Jace Medical provides a range of services and treatments, including outpatient services across a range of medical specialties; diagnostic tests and investigations and surgical day case procedures.	

2.0 Inspection summary

A short notice announced inspection was undertaken to Jace Medical on 30 July 2025 from 10.00 am to 5.30 pm and on 31 July 2025 from 10:00am to 12:45pm. Feedback of the onsite inspection findings was delivered to Ms McCurry, Registered Manager on the days of the inspection.

This inspection focused on four main key themes: organisational and clinical governance; the safe practice for provision of day surgery/endoscopy services, staffing arrangements and the management of medicines.

Examples of good practice were evidenced in patient safety in respect of the management of the patients' care pathway and engagement to enhance the patients' experience.

Two areas for improvement have been identified against the regulations to ensure the endoscopy register and surgical register are fully completed on a consistent basis and to ensure patient records are completed in keeping with best practice guidance. These areas should be included in Jace Medical's auditing schedule.

Nine areas for improvement have been identified against the standards in relation to ensuring; completion of the surgical safety checklist based on World Health Organisation (WHO) guidance; staffing arrangements in the recovery area are suited to the needs of the service; implementation of an audit of pathology services; all staff undertake a robust induction process; all relevant staff receive medicines management training; records of medicines on admission and at discharge; monitoring medicines expiry dates and the recording of temperature of medicines storage areas.

It was determined that governance and oversight arrangements are in place, addressing the areas for improvement identified as a result of this inspection will strengthen these arrangements. Mr Doherty and Ms McCurry were receptive to all matters discussed and displayed a keenness to ensure Jace Medical is fully compliant with the legislation, standards and best practice guidance.

3.0 How we inspect

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

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

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

During the inspection we spoke with Mr John Doherty, Responsible Individual, Ms McCurry, Registered Manager and other staff members.

The inspection team undertook a tour of the premises and Ms McCurry facilitated 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).

4.0 What people told us about the service

Posters were issued to Jace Medical by RQIA prior to the inspection inviting clients and staff to complete an electronic questionnaire. No completed client or staff questionnaires were submitted to RQIA prior to the inspection.

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 Jace Medical was undertaken on 19 August 2024; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Are there safe practices in place for the provision of day surgery/endoscopy services?

We reviewed the arrangements for the provision of endoscopy and day surgery in the hospital as outlined in their statement of purpose and categories of care. The review of endoscopy and day surgery arrangements evidenced that the service largely operates in accordance with best practice and national standards to ensure care delivery is safe and effective. It was confirmed that the hospital provides a day surgical service and endoscopy service largely under local anaesthesia or intravenous sedation. However, a small number of surgical procedures have recently been provided under general anaesthetic (GA) which is further discussed in this section of the report.

The scheduling of patients for endoscopy and day surgery procedures is co-ordinated by Jace Medical management with the involvement of senior endoscopy and theatre staff. Scheduling will take into account individual patient requirements, staffing levels, the nature of the endoscopy procedure and any associated risks.

The patient is sent information about the procedure and any preparation necessary in advance, together with the consent form. Patients will be admitted to an individual cubicle within the admission/recovery bay.

The consent process is completed by the consultant carrying out the procedure as part of the admission process. The patient is then escorted to the procedure room.

It was confirmed that the consultant and nursing staff will be present during the procedure, all with identified roles. There is an identified member of nursing staff with relevant experience in charge, during all procedures.

Whilst a surgical safety checklist based on World Health Organisation (WHO) guidance was in place, it was noted to be inconsistently completed and compliance had not been routinely robustly audited through the hospital's auditing process. An area for improvement has been identified against the standards on this matter.

It was confirmed that patients are observed during and after the endoscopy or day surgery procedure by appropriately trained staff. However, with the introduction of day surgery under GA it was noted that the staffing levels had remained unchanged in the recovery area and did not reflect the staffing levels required for this type of anaesthetic. An area for improvement has been identified against the standards to ensure there are adequate numbers of appropriately trained staff in the recovery area to provide safe care.

Patients are discharged by nursing staff in accordance to the hospital's agreed discharge criteria. 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.

An endoscopy and a surgical register for each procedure room is maintained for all endoscopy and surgical procedures undertaken in the hospital. However, on review it was noted that full details of the surgeon and the nursing staff were not always completed. An area for improvement has been identified against the regulations to ensure the endoscopy and surgical registers are appropriately completed and routinely audited to ensure compliance.

Supplies of sterile instrument packs and reprocessed endoscopes are obtained from an approved sterile services department under contract from a health and social care trust. There are robust measures in place to monitor the traceability of all surgical instruments used in the clinic. Clinical equipment was evidenced to be clean and fit for purpose, and traceability labels were used to identify when equipment had been cleaned.

A wide range of comprehensive policies and procedures were in place to ensure that safe and effective care is provided to patients, however a number were found to have exceeded their review date. Following inspection the relevant updated policies and procedures were submitted to RQIA. Advice was provided to further develop some policies and procedures to ensure they are reflective of local arrangements and in accordance with good practice guidelines and national standards.

Three completed day surgery patient care pathways and endoscopy patient care pathways were reviewed. They were found to provide a framework to record admission, medical history, infection prevention and control status, medication, observations on admission, pre-procedure checklist, venous thromboembolism (VTE) assessment, WHO surgical checklist, intra-procedure details, traceability details, post procedure observations and a discharge record. However, details such as the WHO surgical checklist (as previously mentioned), VTE assessment, wound details, recovery records and discharge record were not consistently completed. An area of improvement has been identified against the regulations to ensure patient care records are fully completed and a robust patient record audit is implemented.

There were procedures for the collection, labelling, storage, preservation, transport and administration of specimens. Staff clearly described detailed procedures for the management of specimens.

It was advised to ensure a clear procedure for reporting results to the appropriate clinical staff and GP was in place. It was noted that the pathology collection log did not reconcile with the specimen log. An area of improvement has been identified against the standards to ensure robust and accurate recording of specimens and a robust pathology audit is implemented. It was confirmed there is a contract in place with a pathology laboratory service.

An emergency trolley is located in Unit 9/10 and checked daily by nursing staff. It was advised to attach the sheets outlining the emergency equipment and drugs contents to the emergency trolley, to ensure ease of access in the event of a medical emergency. Emergency medicines, oxygen and equipment were all in date and clear stock control is in place. Medical emergencies were discussed including the management of a massive blood loss emergency in relation to the type of surgical and endoscopy procedures provided. It was advised to develop a massive blood loss policy and procedure and consider the establishment of a massive blood loss tray. Following the inspection evidence was submitted confirming the action taken by Jace Medical to address this matter.

It was confirmed all staff have received basic life support training within the last year. With the provision of surgical procedures under GA, the availability of at least one member of staff with advanced life support (ALS) training was discussed. It was confirmed that the consultant anaesthetist will have ALS however as they may be engaged in the delivery of GA to patients, it was advised to consider additional staff undertake ALS training.

Addressing the areas of improvement identified will ensure the safe and effective provision of the day surgery and endoscopy services.

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

The arrangements for the recruitment and selection of staff were reviewed. A recruitment policy and procedure was in place that was in keeping with legislation and best practice guidance.

A staff register was available to review and was found to contain staff details in keeping with legislation. It was noted that a small number of entries did not have the actual date of commencement recorded. Following the inspection, RQIA received confirmation that this matter had been addressed.

The staff register evidenced that a number of staff had been recruited since the last RQIA inspection. The personnel files of two newly recruited staff members were reviewed and evidenced that all of the information required by legislation was obtained and retained in the file, with the exception of two references for one staff member. This was discussed with Ms McCurry who advised that both references had been requested but had not yet been received. Following the inspection RQIA received confirmation that this matter had been addressed.

A review of duty rotas and discussion with Ms McCurry evidenced that there sufficient staff were available in various roles to fulfil the needs of the clinic and patients. Theatre, recovery and clinical staff are allocated to work as and when theatre lists are taking place. Recruitment challenges were discussed with Mr Doherty and Ms McCurry, and whilst some staff do not work permanently in Jace Medical, it was demonstrated that the members of the clinical and theatre teams were suitably qualified and experienced staff who work regularly in Jace Medical.

It was identified that a formalised induction programme had not been established. The importance and value of a robust induction process for staff, and in particular, bank staff, was discussed with Ms McCurry. Following the inspection Ms McCurry provided RQIA with copies of induction programme templates for different staff groups. An area for improvement has been identified against the standards to ensure that any person working in Jace Medical completes an induction programme relevant to their role and responsibilities within the hospital.

Staff told us that there were good working relationships throughout the hospital and there was clear evidence of multidisciplinary working.

It was confirmed that there is a system in place to review the registration details of all health and social care professionals with their professional bodies. Records were available for review in this regard.

It was determined that appropriate staffing levels were in place to meet the needs of patients and addressing the area for improvement identified will ensure that staff are suitably trained to carry out their duties.

5.2.3 Medicines management

Written policies and procedures for the management of medicines including controlled drugs were in place. Systems were in place to ensure that all staff involved in the management of medicines had read and understood the policies and procedures.

Ms McCurry and staff spoken with advised that there were no core/permanent staff. Medical staff and bank nurses were responsible for ensuring that their medicines management training was up to date. Bank nurses were asked to read Jace Medical policies and procedures relating to medicines management as part of their induction, however competency assessments were not completed. Systems should be in place to ensure training on medicines management is provided for nurses and doctors as part of their induction, and refresher training is also provided in accordance with the hospital's mandatory training programme. An area for improvement was identified against the standards in this regard.

The kardexes selected for review were completed accurately, and included the patient's weight, VTE risk assessment and allergy status. In relation to medicines administration, the records reviewed indicated medicines had been administered as prescribed. Ms McCurry advised that only a small number of medicines had been administered since the hospital opened.

The arrangements for reconciling medicines prior to any treatment, including day procedures were reviewed. We were advised that details of currently prescribed medicines were obtained as part of the patient's initial consultation and prior to all day procedures. A sample of patients' notes was provided for review; a list of the patients' currently prescribed medicines was not maintained. An area for improvement was identified against the standards in this regard.

Ms McCurry advised that when medicines are supplied to patients at discharge they were packaged and labelled appropriately. Review of a sample of patient notes indicated that records of medicines supplied at discharge were not maintained. An area for improvement was identified against the standards in this regard.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Medicines were requisitioned from a wholesaler and a local community pharmacy by designated staff only. Separate requisition and receipt records were in use for general medicines and controlled drugs. Ms McCurry advised that medicine invoices would be filed separately from all other invoices from the date of inspection onwards. This will readily facilitate the audit process.

Medicine storage areas were observed to be clean, tidy and organised. Medicines were stored safely and securely in the locked cupboards within the theatre and procedure room. The limited storage space within the medicines cupboards was discussed with Ms McCurry who agreed to review storage space periodically to ensure capacity still met the needs of the service. A small number of expired medicines were observed; these were removed from the medicines cupboards for disposal. A robust system to alert staff of the expiry dates of medicines including medicines with a limited shelf life, once opened should be implemented. An area for improvement was identified against the standards in this regard.

Appropriate arrangements were in place for the disposal of medicines. Staff were reminded that part ampoules of controlled drugs should be denatured prior to disposal.

Controlled drug cabinets and a medicine refrigerator were available for use as needed. The temperatures of the medicine refrigerator and storage areas were not monitored and recorded daily; this is necessary to ensure medicines are stored according to the manufacturers' instructions. An area for improvement was identified against the standards in this regard.

Standard Operating Procedures (SOPs) that cover all aspects of the management of controlled drugs were in place. The Accountable Officer is responsible for the management of controlled drugs and related governance issues in their organisation; the Accountable Officer for Jace Medical is the registered manager and this is reflected in the controlled drugs policy.

Mostly satisfactory arrangements were in place for the storage, security, administration and recording of controlled drugs. Stock balances were reconciled at the start and end of each shift when the theatre or procedure room were in use. One running balance in the controlled drug register had not been carried forward correctly; this was addressed at the inspection. Ms McCurry was reminded of the importance of ensuring the name, form and strength of each controlled drug was clearly recorded on each page of the controlled drug register.

Systems were in place for the management of drug and medical device alerts and to report any safety problems relating to medicines, medical devices, blood and defective medicines to the Medicines and Healthcare Regulatory Agency (MHRA). It was evident that a database of all alerts received and the actions taken in response was maintained.

As previously outlined, we were informed that there has been limited use of medicines within the service and that there have been no medication related incidents. It was confirmed that an effective incident reporting system was in place to identify record, report and share learning from any medicine related incidents. Ms McCurry was aware that medicine related incidents must be reported to RQIA and any which involve controlled drugs must be reported to the Local Intelligence Network.

A range of audits are completed to ensure the safe and effective management of medicines including a controlled drugs audit and a medication safety audit.

Guidance on a more effective auditing system to cover all areas of medicines management including those identified at this inspection was provided.

Addressing the areas for improvement identified will strengthen the arrangements for the safe storage and management of medicines including controlled drugs.

5.2.4 Organisation and clinical governance

It was demonstrated that there was a clear management structure with defined lines of responsibility and accountability.

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. It was confirmed that Mr Doherty, Responsible Individual, is present in the establishment on an ongoing basis and is involved in the delivery of day surgery services, therefore six monthly unannounced quality monitoring visits are not required.

Policies and procedures were available for staff reference and discussion with Ms McCurry confirmed that a structure is in place to ensure that policies are being reviewed in a systematic manner. Staff reported they were aware of the policies and how to access them.

The Competition and Markets Authority (CMA) requires all hospitals and consultants offering private treatment to submit data to Private Healthcare Information Network (PHIN) as the Information Organisation for private healthcare. However, it has been confirmed that diagnostic day case services are not required to register with PHIN at this time.

Clinical and Medical Governance

Clinical governance within Jace Medical is overseen by the Medical Advisory Committee (MAC). Terms of reference for the MAC were in place and these have been developed in accordance with Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments (2014).

It was evidenced that the MAC meetings have standing agenda items and are used as a forum to discuss clinical governance issues, the appointment and renewal of practising privileges agreements, the review of performance indicators, corrective action in relation to adverse clinical incidents and any other untoward event or near miss, the outcome of completed audits, staff training compliance figures, the review of complaints/compliments and also estate management matters. These meetings were being undertaken on a quarterly basis in line with the criteria set out in Standard 30.

A team of consultant surgeons who have specialist qualifications and skills work in Jace Medical.

Discussion with Ms McCurry and a review of records confirmed that arrangements are in place to monitor individual consultant's professional indemnity, annual appraisal and registration status with the General Medical Council (GMC).

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 are doing well and how they can improve. As part of the revalidation process, responsible officers (RO) make revalidation recommendations 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 the areas of the doctor's work. It was established that all doctors working in the clinic have a designated RO. Mr Doherty has established links with ROs of the doctors working in the organisation should a concern arise.

One consultant is considered to be a wholly private doctor as they are not affiliated with the HSC sector in Northern Ireland (NI) and are not on the Primary Medical Performers List (PMPL) in NI. The following was confirmed:

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

Whilst it is the responsibility of GMC registrants to keep up to date with their continuing professional development (CPD) activities, the CPD learning activities may not meet with legislative mandatory training such as fire safety, safeguarding adults, children and young people, infection prevention and control and resuscitation.

We reviewed the arrangements for the oversight and recording of induction and on-going training for consultants to ensure all consultants working in Jace Medical complete mandatory and other training, supervision and appraisal in accordance with best practice guidance.

Discussion with Ms McCurry and a review of records demonstrated that a staff training matrix was in place that included all staff and provided up to date information on staff training compliance. One consultant's training records were not available for our review. This was discussed with Ms McCurry and following the inspection RQIA received confirmation that the identified consultant had completed mandatory training in keeping with best practice guidance.

Practising Privileges

The only mechanism for a medical practitioner to work in a registered independent hospital is either under a practising privileges agreement or through direct employment by the hospital. Ms McCurry informed us that all medical practitioners working in Jace Medical are not directly employed and therefore have a practising privileges agreement in place.

A detailed policy and procedural guidance for the granting, review and withdrawal of practising privileges agreements was in place. This procedure includes the practising privileges applicant having an interview/meeting with the medical director or the registered manager.

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. It was noted that the practising privileges application also includes a requirement to demonstrate completion of specific areas of mandatory training and provide a copy of their annual appraisal document within a specific time frame.

A review of records evidenced that there was a written practising privileges agreement between each consultant and Jace Medical, setting out the terms and conditions. It was also evidenced that the practising privileges agreements in place, clearly stated each consultant's scope of practice.

Ms McCurry was aware that practising privileges agreement should be reviewed at least every two years.

As previously discussed, practising privileges matters are discussed and reviewed during the MAC meetings.

Ms McCurry was advised that the Jace Medical website should provide information on consultants' eligibility for the granting of practising privileges in Jace Medical.

Discussion with the Ms McCurry demonstrated that good oversight arrangements of the granting of practising privileges agreements were in place.

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.

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

This inspection identified areas requiring improvement and compliance monitored by regular auditing of these areas. These matters were discussed with Ms McCurry who confirmed that these areas would be included in the Jace Medical audit schedule. Further information is provided in section 5.2.1.

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 McCurry confirmed that any learning from incidents would be discussed with staff.

There was a process in place for analysing incidents and events to detect actual or potential trends or weakness in a particular area, in order that a prompt and effective response can be considered at the earliest opportunity.

During discussion it was confirmed that any significant incident and/or themes reported will be reviewed by Mr Doherty and discussed at the MAC meetings.

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 Department of Health (DoH) guidance on complaints handling.

Ms McCurry 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 audit confirmed that no complaints have been received since the previous RQIA inspection. Ms McCurry stated that should a complaint be received this 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. It was confirmed that any learning coming out of a complaint will be disseminated across all staff groups to drive quality improvement of this service.

The management of complaints is reviewed on an ongoing basis with an over-arching quarterly audit of complaints undertaken to ensure any trends or themes emerging will be identified at an early stage. The quarterly audit of complaints is included as standing agenda item for the MAC meetings.

Risk Management

Systems were in place to support good risk management within the hospital. This ensures that the likelihood of adverse incidents, risks and complaints are minimised by effective identification, prioritisation, treatment and management.

Risks were documented, collated and tracked through the use of a risk register which provided assurance about the effective identification and management of risk. The content of the risk register was discussed with Mr Doherty who was satisfied that all risks in connection with the establishment, treatment and services are identified, assessed and managed.

It was determined that governance and oversight arrangements are in place, addressing the areas for improvement identified as a result of this inspection will strengthen these arrangements.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with **The Independent Health Care Regulations (Northern Ireland) 2005** and the **Minimum Care Standards for Independent Healthcare Establishments (July 2014).**

	Regulations	Standards
Total number of Areas for Improvement	2	9

Areas for improvement and details of the QIP were discussed with Ms Delma McCurry, Registered Manager, as part of the inspection process and can be found in the main body of the report. 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 21(1),(3) Schedule 3 Part II (2) **Stated:** First time **To be completed by:** 31 July 2025	The responsible individual shall ensure the endoscopy and surgical registers are appropriately completed and routinely audited to ensure compliance. Ref 5.2.1
	Response by registered person detailing the actions taken: Completed.Immediate effect ,both registers now audited following all procedure lists include and now form part of a monthly Patient Record audit.
Area for improvement 2 **Ref:** Regulation 21(1) **Stated:** First time **To be completed by:** 31 July 2025	The responsible individual shall ensure patient records are fully completed as outlined in section 5.2.1 and shall implement a robust patient record audit. Ref: 5.2.1
	Response by registered person detailing the actions taken: Completed.A patient record auditing tool has been developed and is completed monthly.
Action required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments (July 2014)	
Area for improvement 1 **Ref:** Standard 32.1	The responsible individual shall ensure the surgical safety checklist based on World Health Organisation (WHO) guidance is in place, consistently completed in patient records and

Stated: First time **To be completed by:** 30 September 2025	completion compliance is robustly audited through the hospital's auditing processes. Ref:5.2.1
	Response by registered person detailing the actions taken: Completed.The surgical safety checklist(WHO)is now included in a patient record audit on a monthly basis.
Area for improvement 2 **Ref:** Standard 32.11 **Stated:** First time **To be completed by:** 31 July 2025	The responsible individual shall ensure there are adequate numbers of appropriately trained staff in the recovery area to provide safe care. Ref: 5.2.1
	Response by registered person detailing the actions taken: Completed. One recovery nurse for each patient who has a general anaesthetic.Another recovery nurse provides safe care for patients who have a local anaesthetic.
Area for improvement 3 **Ref:** Standard 34 **Stated:** First time **To be completed by:** 30 August 2025	The responsible individual shall ensure robust and accurate recording of pathology specimens and the implementation of a robust pathology audit. Ref: 5.2.1
	Response by registered person detailing the actions taken: Completed.SOP for collection of Specimens has been reviewed.All nursing staff must read and sign and date this.Pathology audit implemented and audited monthly.
Area for improvement 4 **Ref:** Standard 13.3 **Stated:** First time **To be completed by:** 31 July 2025	The responsible individual shall ensure that any person working in Jace Medical completes an induction programme relevant to their role and responsibilities within the hospital. Ref: 5.2.2
	Response by registered person detailing the actions taken: Completed.Induction programme developed and implememnted.Induction programmes tailored to individual role and responsibilities.
Area for improvement 5 **Ref:** Standard 25 **Stated:** First time	The responsible individual shall ensure all staff receive training and competency assessment on medicines management as part of their induction, and refresher training in accordance with the hospital's mandatory training programme.

To be completed by: 30 September 2025	Ref: 5.2.3
	Response by registered person detailing the actions taken: Completed.Included in induction programme.Medication Management training must be up to date.
Area for improvement 6 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 30 September 2025	The responsible individual shall ensure that a list of each patient's currently prescribed medication is available within their medicines record. Ref: 5.2.3
	Response by registered person detailing the actions taken: Completed.SOP for the Admission process has been reviewed.An Admission checklist has been developed and implemented.This is completed by the recovery nurse for each patient.
Area for improvement 7 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 31 July 2025	The responsible individual shall ensure that a record is maintained of the name, strength and quantity of all medicines supplied at discharge. Ref: 5.2.3
	Response by registered person detailing the actions taken: Completed.SOP for Recovery and Discharge reviewed.Discharge checklist developed and implemented which includes a medication list check and a Home Leave book has now been implemented for medication
Area for improvement 8 **Ref:** Standard 26 **Stated:** First time **To be completed by:** 31 July 2025	The responsible individual shall implement a date checking system to ensure that medicines do not remain in use after their expiry. Ref: 5.2.3
	Response by registered person detailing the actions taken: Completed.Weekly audit of medication expiry dates implemented.Medication Disposal book implemented.Monthly date checks already included in Medication Safety monthly audit.
Area for improvement 9 **Ref:** Standard 26 **Stated:** First time **To be completed by:**	The responsible individual shall ensure that the temperature of the medicine refrigerator and storage areas are monitored daily to ensure that medicines are stored at the manufacturers' recommended temperature. Ref: 5.2.3

31 July 2025	**Response by registered person detailing the actions taken:** Completed.Immediate effect.Daily medication refrigerator temperatures monitored daily and recorded.

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

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