The Regulation and Quality Improvement Authority

Inspection Report

19 and 20 March 2025

Kingsbridge Private Hospital North West

Type of service: Independent Hospital
Address: Church Hill House, Ballykelly, BT49 9HS
Telephone number: 028 7776 3090

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: Kingsbridge Healthcare Group Limited **Responsible Individual:** Mr Mark Regan	**Registered Manager:** Mr Anthony McKenna **Date registered:** 22 August 2022
Person in charge at the time of inspection: Mr Anthony McKenna	**Number of registered places:** 38 Inpatient beds (inclusive of two critical care beds) 10 Day surgery beds
Categories of care: Independent Hospital (IH) Acute Hospital Inpatient (AH) Acute Hospital Day surgery (AH(DS)) Private Doctors (PD) Prescribed Technologies PT (L) Endoscopy PT(E)	
Brief description of the accommodation/how the service operates: Kingsbridge Private Hospital North West (KPHNW) provides a wide range of surgical, medical and outpatient services for both adults and children. The hospital is registered to accommodate up to 38 patients as in-patients and 10-day surgery beds. The hospital has four main operating theatres, three of which have a laminar clean air system specifically designed for orthopaedic and ophthalmic surgery. The hospital also has a dedicated endoscopy suite; an x ray department and magnetic resonance imaging (MRI) scanner; a central sterile services department (CSSD), and a range of consulting rooms. The in-patient accommodation, which is ensuite, and day surgery rooms are situated on the ground floor of the hospital. KPHNW is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital (IH) with prescribed techniques or prescribed technology: establishments using a Class 3B or Class 4 lasers PT (L). **Equipment available in the service:** **Laser Suite** Manufacturer: Ceram Optec Bioletic Model: Cerelas E Serial Number: 4291-G Laser Class: 4 Wavelength: 1470 ± 30 nm Manufacturer: Zeiss	

Model:	Visulas YAG III
Serial Number:	1272074
Laser Class:	4
Wavelength:	1064nm

Types of treatment provided:
Vascular treatments using Cerelas E
Capsulotomy procedures using Visulas YAG III

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.

2.0 Inspection summary

A short notice announced inspection was undertaken to the KPHNW on 19 and 20 March 2025.

RQIA's Laser Protection Advisor (LPA) attended the inspection on 19 March 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.

The onsite care component of the inspection was undertaken by one senior inspector, four care inspectors on 19 and 20 March 2025 and RQIAs appointed laser protection advisor (LPA) on 19 March 2025.

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

Examples of good practice were evidenced in maintaining patient confidentiality, ensuring the core values of privacy and dignity were upheld and providing the relevant information to allow patients to make informed choices and engagement to enhance the patients' experience.

One area of improvement has been identified against the standards to ensure scheduling of patients for surgical procedures takes into account; the patient requirements for the entire patient pathway; staffing levels; nature of the surgical procedure; facilities and equipment available; and any associated risks.

The Liz Dallas Outpatient Department is located within the grounds of KPBHNW. During discussion it was identified that an outpatient clinic, operated by a private doctor, is provided in the Liz Dallas Outpatient Department. Mr McKenna was advised to submit a variation to registration application to add the Liz Dallas Outpatient Department to the registration of KPHNW. Mr McKenna was receptive to this advice and a variation to registration application was submitted to RQIA following the inspection.

Feedback of the inspection findings was delivered to the KPH management group upon conclusion of the inspection and included staffs comments on the scheduling of patients for surgical procedures. This matter is discussed further in sections 4.0 and 5.2.4. Senior management agreed to review this matter as a priority.

Addressing the area for improvement, and following advice provided during the inspection, will strengthen and improve arrangements to ensure services and treatments are provided in a safe environment that minimises risks to patients.

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 days 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.

The inspection team undertook a tour of the premises and the inspection was facilitated by Mr McKenna and other staff members.

The inspection team spoke with; Mr Regan; Mr McKenna; the medical director; the theatre manager; the deputy theatre manager (briefly); three theatre nursing staff; the post anaesthesia care unit (PACU) manager; a recovery nurse; a resident medical officer; an inpatient unit ward sister; two inpatient unit deputy sisters; two inpatient unit staff nurses; a wound care nurse and members of the hospital liaison team.

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 QIP.

4.0 What people told us about the service

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

No patients or relatives/visitors submitted responses.

Two inpatients spoken with described having a very positive experience of the surgical services. They confirmed that staff were professional, compassionate, that their pain was well managed and felt they were kept well informed at each step of their patient journey.

Six staff submitted questionnaire responses. A review of the questionnaire responses revealed a mixed response from staff when asked if they found the care provided was safe, effective and if patients were treated with compassion. Four staff indicated they were dissatisfied or undecided regarding patient safety, while two respondents indicated they were satisfied or very satisfied in this regard.

Five staff indicated they were satisfied that patients were treated with compassion and one respondent was undecided, four respondents indicated they were satisfied that patient care was effective and two respondents were either dissatisfied or undecided.
When asked if they found the service to be well led, two staff members indicated they were undecided in this regard and four staff were either dissatisfied or very dissatisfied.

Five of the six staff responses included comments, some of which noted dissatisfaction regarding the scheduling of patients for surgical procedures, the impact of this on staff, and indicated a lack of managerial support. This matter is discussed in sections 2.0 and 5.2.4 and an area for improvement against the standards has been made in this regard.

Staff comments also included a request for additional external training opportunities and changes to the way in which training is currently requested and approved. One staff member commented positively on maintaining patient dignity.

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 care inspection to KPHNW was undertaken on 7 March 2022; 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 KPHNW.

As previously outlined, Mr Regan is the responsible individual and Mr McKenna is the registered manager with overall responsibility for the day to day management of KPHNW. Where the business entity operating a registered service is a corporate body or partnership or an individual owner who is not in day to day management of the establishment, unannounced quality monitoring visits by the registered provider must be undertaken and documented every six months; as required by Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005.

This matter was discussed with the senior management team at the conclusion of the inspection. As Mr Regan is the responsible individual for three independent hospitals registered with RQIA, this matter will be followed up with Mr Regan separately.

KPHNW is part of the Kingsbridge Healthcare Group (KHG) and is supported by well-established governance arrangements. The Quality Improvement Strategy 2025 is in place which outlines five strands of improvement for the Kingsbridge Healthcare Group.

A review of the Governance and Compliance Strategy and Framework demonstrated that the KHG has developed a robust governance model that involves a network of quality teams operating through all levels and disciplines within the organisation. These teams allow for communication throughout the organisation ensuring a steady flow of information.

Each hospital has a local management team (LMT) who meet weekly with departmental heads to report and discuss on clinical governance and compliance issues such as complaints, incidents and learning outcomes with action plans and timeframes.

The local governance and quality team (LGQT) meet monthly to discuss and work through their local quality agenda. Standing core agenda items include risk management and clinical effectiveness including incidents and complaints, audit, policy updates/ratification, appraisals, training and continuous professional development (CPD), patient and staff experience and quality management systems.

The LGQT will create action plans and will report to and seek advice from the Medical Advisory Committee (MAC) as required. This is discussed further within the next section of this report.

The LGQT provides upward and downward assurance within the KHG for the clinical governance and the quality agenda. Attendees at the meeting are required to ensure appropriate cascade of information to staff groups. Minutes and action plans are circulated to members to facilitate discussion at local management and team meeting level.

A quarterly group administrative governance and quality team meeting also takes place. Attendees are representative departmental managers or leads from all areas of the KHG. The agenda for the group focuses on governance, quality key performance indicators (KPIs), risk management and education. The rolling agenda includes updates from every departmental manager regarding any group learning outcomes from complaints, incidents, trend analysis, audit findings, operational issues and business development issues. This group produces a quarterly and annual quality report to the Board.

Risk management procedures were reviewed which provided assurance that risks identified with the hospital, including treatment and services provided, are identified, assessed and managed appropriately.

The Competition and Markets Authority (CMA) requires that all hospitals and consultants offering private treatment submit data to the Private Healthcare Information Network (PHIN) as the Information Organisation for private healthcare. This provides people considering private healthcare with clear information to help them make an informed choice of which consultant and hospital is right for them.

We were informed that an electronic system for receiving patient experience feedback has been implemented which enables the KPHNW to feed into PHIN. There was also evidence of patient feedback being shared with staff as a means of continually evaluating and driving service improvement.

A range of policies and procedures were accessible and evidenced. Policies and procedures examined were in date with a planned review date recorded and they were retained in a way that is easily accessible to all staff.

Discussion with staff and a review of records evidenced that staff meetings take place every month and minutes were available to review.

Clinical and medical governance

The KHG Board of Directors (the Board) requires consultant medical practitioners to practice in accordance with the General Medical Council (GMC) guidance 'Good Medical Practice', completing appropriate appraisal and revalidation requirements and adhering to the KHG's practising privileges agreement.

As previously outlined, LGQT meet on a monthly basis and assist the Board in its oversight and integrity of KPH's clinical governance arrangements, including responsibilities regarding RQIA and the PHIN.

The duties of the LGQT include ensuring there is a robust mechanism for reporting and recording of all clinical incidents and to regularly review all such incidents; consider issues of concern relating to the clinical practice of an individual, where identified, and bring to the attention of the MAC; review and monitor all complaints relating to clinical issues; to have oversight and monitor the risk management system and controls in place and escalate any major risks identified to the Board; to ensure the MAC is in receipt of all consultants practising privileges documentation; to have oversight of the duties and responsibilities of the Resident Medical Officers and monitor their performance on a regular basis.

In conjunction with the MAC, the LGQT will identify areas appropriate for medical audit and will oversee these audits and outcomes.

Audits recently undertaken included: inpatient falls audit; patient complaints audit; breast surgery surgical site infection audit; as well as quarterly infection prevention and control audits.

In addition to the above, a number of management reports providing an overview of the orthopaedic and adenotonsillectomy procedures completed at KPHNW had been completed and were available for review by inspectors. It was confirmed that audit findings, including IPC audit findings, are shared at the LMT and LGQT meetings and at the IPC steering group meetings.

The MAC meets quarterly with responsibility for surgeon performance and surgery specific matters. As discussed, the LGQT ensures that all the documentation for consultants with practising privileges are in place including checking registration with the GMC, professional indemnity and appraisals. 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. A review of MAC meeting minutes confirmed that these meetings were being undertaken on a quarterly basis in line with the criteria set out in Standard 30.

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 ensure doctors are reviewing their work. As part of the revalidation process, ROs make a revalidation recommendation to the GMC. It was established that KHG is registered with the GMC as a designated body and have an appointed RO.

A number of consultants 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 Northern Ireland Primary Medical Performers List (PMPL). A review of a sample of three consultants' details confirmed evidence of the following:

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

Appraisal is a key part of revalidation and includes the appraisee providing evidence of their individual continuing professional development (CPD) activities undertaken in accordance with the GMC Good Medical Practice. It was demonstrated that systems have been strengthened to ensure they have an accurate and up to date position on medical appraisal status which clearly evidences any delay. A system was in place to record when appraisals have been received. If there has been a delay, the date the appraisal is expected to be submitted by is documented.

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

Since the previous RQIA inspection, it was good to see that a fresh approach has been taken to ensure all consultants complete KHG's mandatory training requirements and this begins at the point of a consultant making an application to work in KPHNW. A review of training records demonstrated that progress is being made in this regard. As previously discussed, training compliance rates are included in the quarterly LGQT and MAC meetings.

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.

It was established that the majority of consultants who work in KPHNW are not directly employed and work under a practising privileges agreement.

A detailed policy and procedural guidance for the granting, review and withdrawal of practicing privileges agreements was in place. It was evidenced that this policy states that 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.

As previously discussed, a review of the practising privileges agreement confirmed that there is clear and accurate information regarding when annual appraisals should be submitted and clear escalation actions are outlined if annual appraisals are not submitted within the specified time.

It was also demonstrated that the practising privileges application now includes a requirement to demonstrate completion of specific areas of mandatory training and also ongoing registration with the Information Commissioner's Office (ICO). A practising privileges portal is being rolled out to enable medical practitioners to submit the required documentation electronically. This electronic system will also have the facility to issue reminders and other communications to medical practitioners.

It was demonstrated that practising privileges matters are discussed and reviewed during the MAC meetings.

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 during the LMT, LGCT and MAC meetings.

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 KHG's audit schedule. As previously discussed, the outcomes are monitored by the LGQT 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.

It was demonstrated that 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

The previously discussed Governance and Compliance Strategy and Framework provides an overview of the mechanisms in place, roles and responsibilities at all levels throughout KPHNW, to oversee, report and respond to clinical risks, incidents and near misses. This includes reporting requirements to external bodies as required and arrangements for the management of national safety alerts. A Group Adverse Incident policy further describes the internal electronic reporting mechanism, which is accessible to all staff and corresponding investigation pathways following categorisation of the incident.

Review of meeting minutes and discussion with the management team confirmed that any learning from incidents would be cascaded to relevant staff members. 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, the MAC and health and safety committees.

Complaints Management

A copy of the KPHNW complaints policy was available for review and was found to be in line with 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.

Review of the complaints log confirmed that all complaints received in the previous 12 months were investigated and responded to in line with the complaints policy. Details of all communications with complainants, any investigation undertaken and the resultant actions were documented. Any learning from the investigation of complaints is disseminated across all staff groups to drive improvement in the quality of the service.

A recent complaints audit was available for review during the inspection. The audit was up to date and capable of reflecting any themes emerging from complaints analysis.

The KPHNW management team described an effective governance structure that provides a process and system of accountability to support the delivery of good quality service and to monitor and maintain high standards of care.

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 in keeping with legislation and best practice guidance.

The KHG training academy provides an ongoing training programme. All staff are facilitated and encouraged to take part in ongoing training to update their knowledge and skills, relevant to their role. The training academy provides Mr McKenna with a monthly update of completed staff training.

An electronic system was in place to monitor all aspects of ongoing professional development and a record was retained of all training and professional development activities. A review of the electronic system confirmed a high level of compliance. Staff had either completed or were in the process of completing training as outlined in the RQIA training guidance and legislation.

A sample of personnel files of newly recruited staff evidenced that relevant recruitment records had been sough; reviewed and stored as required. 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 authorised operators had completed a programme of induction.

Discussion with Mr McKenna, 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 twice yearly 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 that staff were suitable trained to carry out their duties.

5.2.3 Are there safe practices in place for the day surgery and inpatient services?

The arrangements for the provision of day surgery and inpatient services as outlined in the statement of purpose and categories of care were reviewed.

Discussion with staff confirmed that referrals can be received from a patient's general practitioner (GP) or as part of the health and social care (HSC) waiting list initiative.

It was confirmed that patients are reviewed by a consultant, anaesthetist and a pre-operative nurse in the outpatient department prior to admission. Patients are provided with information regarding their treatment which includes the risks and benefits associated with their planned programme of care. It was also confirmed that interpreting services are arranged by the booking office when required.

The role of the hospital liaison nurse (HLN) was discussed with staff and it was confirmed that patients are contacted by the HLN prior to admission. It was confirmed that the HLN gathers and collates information regarding the patient's admission, including the patient's medical history and management of activities of daily living. This information is then communicated to the inpatient unit staff. The HLN also contacts the patient prior to admission to confirm discharge arrangements and will also contact the community team if additional arrangements are required.

There is a day procedure unit and an inpatient unit that is divided into two surgical wards.

In the day procedure unit, we observed care, spoke to staff and reviewed a number of patient records. We found that the facilities and premises were appropriate for the services that were delivered. The day care unit contains outpatient pods next to the nurses' station. The pods function as a quiet, comfortable and private space for patients pre and post procedure. The service takes account of the individual needs of children, young people and those close to them with dedicated rooms available and specialist paediatric nursing care.

It was evidenced that care is delivered in a co-ordinated way between the day procedure unit and theatres downstairs, creating an efficient patient flow though the outpatient service. Direct audio communication between each team alerts staff to changes and delays effectively. The day procedure team is part of the daily emergency call safety huddle, which is a drill that takes place every morning with allocated staff.

We reviewed a sample of endoscopy patient records. It was confirmed that staff kept detailed records of patients' care and treatment through the day procedure pathway. Records reviewed were clear, up-to-date and easily accessible to all staff providing care.

We observed that staff took time to interact with patients and those close to them in a respectful and considerate way. There are arrangements in place to assist patients with a disability or who require extra support. Discussion with staff evidenced that there are procedures in place for safe patient discharge and also for day case admission in the event of an outpatient becoming unwell.

Discussion with staff in the inpatient unit confirmed that on admission to the inpatient unit, patients are reviewed by the inpatient nursing and medical staff who complete the patient pathway including pre-operative checklists and risk assessments prior to the patient being transferred to the theatre department.

Observations and discussion with staff confirmed that arrangements were in place to refer patients to other members of the multidisciplinary team based on the patient's assessed need.

It was confirmed that there is a planned programme for discharge in place and that patients are provided with a discharge letter which is shared with the patient's GP, a supply of medications and written information with advice on managing their condition following their procedure. It was also confirmed that patients are provided with details regarding any outpatient review appointments prior to discharge. It was evidenced that information was available for patients to contact the service if they had concerns following discharge.

A sample of patient care records were reviewed and it was confirmed that a comprehensive assessment of their health care needs is completed using evidence based assessment tools. It was noted that patient care records included a contemporaneous note of each patient's medical history and treatment provided. However, it was identified that some patient care records were incomplete. This matter was discussed with Mr McKenna who gave assurances that this matter would be reviewed.

It was good to note the introduction and development of a wound care clinic located in a dedicated room within the inpatient unit. It was confirmed that the clinic provides a wound management service for patients who have undergone surgical procedures within the hospital. Discussion with staff confirmed that arrangements are in place to refer patients, and that wound care appointments are booked by a team of dedicated wound care nurses. It was confirmed that support was available from medical staff and the hospital infection prevention and control (IPC) nurse as required.

During a tour of some areas of the inpatient unit, it was observed that clinical and decontamination areas were clean, tidy and uncluttered.

A range of emergency trolleys containing emergency medicines and equipment are readily accessible in the inpatient unit and day procedure unit. Emergency medicines were stored securely and oxygen was noted to be in date. There were separate adult and paediatric emergency medicines and equipment in place.

It was determined that safe practices were in place for the inpatient and day procedure services.

5.2.4 How does the service ensure that surgical services are safe?

The arrangements for the provision of surgical services in the hospital as outlined in the statement of purpose and categories of care were reviewed. The inspection team evidenced that these services operate in accordance with best practice and national standards to ensure care delivery is safe and effective.

It was confirmed that adult and paediatric surgical services are provided. The scheduling of patients for surgical procedures is co-ordinated by the booking office with senior management and the theatre manager's involvement. The theatre lists are required to take into account the individual requirements of the patient, the type of procedure to be performed, availability of equipment, staffing levels required, and any associated risks.

During the inspection a range of staff raised concerns about the scheduling of theatre lists. On occasions, this has led to increased pressure on staff struggling to provide optimum safe care throughout the patient pathway.

Staff confirmed that they were aware how to raise these matters with management and had done so, however, positive change had not occurred. Concerns expressed by staff members were shared with senior management at the conclusion of this inspection. Senior management responded positively and agreed to review the matter as a priority. An area of improvement has been made against the standards to ensure scheduling of patients for surgical procedures takes into account; the patient requirements for the entire patient pathway; staffing levels; nature of the surgical procedure; facilities and equipment available; and any associated risks. The scheduling must have meaningful involvement of the medical and nursing staff.

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.

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

It was confirmed that patients are observed during and after the surgery procedures by appropriately trained staff. Surgical patients are transferred to the ward area in accordance with recovery area 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.

A surgical register for each theatre was in place and they were found to be largely well recorded in accordance with regulation. It was noted that on a number of occasions, the record of specimens taken was not fully completed. Advice was provided to ensure consistency in recording specimens in the surgical register and to ensure that this is subject to audit. Management gave assurances that this matter would be addressed following the inspection.

It was confirmed that surgical assistants are used in the hospital. A written log and an electronic log is maintained to confirm they have been granted practising privileges with a defined scope of practice for their participation in specific surgery. The surgical assistants have practising privileges with the hospital and operate within a defined scope of practice. This is further discussed in section 5.2.1 of this report.

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

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, in accordance with good practice guidelines and national standards.

There were procedures for the collection, labelling, storage, preservation, transport and administration of specimens. Staff clearly described these procedures and the procedure for reporting results to the appropriate clinical staff and GPs. It was confirmed that there is a contract in place with a pathology laboratory service. The pathology services are subject to internal audit.

A range of emergency trolleys containing emergency medicines and equipment are readily accessible in the theatre and recovery area. Each trolley is checked daily by nursing staff. Emergency medicines were stored securely and oxygen was noted to be in date. There were separate adult and paediatric emergency medicines and equipment in place.

Medical emergencies were discussed including the management of a massive blood loss emergency. There was a separate massive blood loss tray and relevant documentation folder in place. Theatre management confirmed that massive blood loss drills had not taken place and it is hoped that they will be arranged in the near future. This matter was discussed with the management team during feedback and the Medical Director confirmed that following recent consultation with the Western Health and Social Care Trust (WHSCT) on the management of a massive blood loss emergency in KPHNW, there will be a significant change to the protocol. Management confirmed that all the necessary protocols will be devised and training will be provided to relevant staff to reflect the WHSCT and KPHNW agreed management plan for a massive blood loss emergency.

Theatre management confirmed that joint replacement information is provided for the National Joint Registry (NJR) with the consent of patients. The hospital similarly also participates in the Breast and Cosmetic Implant Registry (BCIR). The BCIR register was established to enable the identification of trends, complications relating to implants, and to ensure patients could be traced in the event of a product recall or other safety concern. Review of completed documentation in relation to NJR and BCIR noted that they were well completed.

Patients are observed during surgery and in the recovery room, and the hospital had discharge criteria in place to confirm when patients were well enough to leave theatre recovery and to transfer to the ward area.

It was determined that safe practices were in place for delivery of surgery services and the area of improvement outlined will consolidate this approach.

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

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

A review of the laser safety policy identified that it required further development to include an overarching statement on the approach to laser safety, and make reference to the existence of local rules and treatment protocols. Mr McKenna was receptive to this advice and following the inspection, RQIA received confirmation that this matter had been addressed.

Staffing arrangements were reviewed and it was confirmed that there are appropriately skilled and qualified staff involved in the delivery of services. This includes a team of consultant ophthalmologists, consultant vascular surgeons and supporting staff, which include registered nurses and health care assistants.

As discussed in section 5.2.1 and in conjunction with a review of documentation, it was confirmed that robust arrangements were in place to check the registration status for all clinical staff on appointment and on an ongoing basis.

A review of the laser safety files found that they contained relevant information in relation to the laser equipment in place. There were arrangements in place confirming the support and duties of a certified LPA.

The theatre manager confirmed that all patients have an initial consultation with a consultant ophthalmologist or vascular surgeon who discusses their treatment options and the cost of the surgery.

During the initial consultation, patients are asked to complete a health questionnaire. Systems were in place to contact the patient's general practitioner (GP), with their consent, for further information if necessary.

KPHNW has a list of fees available for each type of surgical procedure provided. Fees for treatments are agreed during the initial consultation and may vary depending on the individual patient's needs and surgery options available to them.

In accordance with General Medical Council (GMC) and the Royal College of Ophthalmologists guidance, patient's meet with their surgeon on a separate day in advance of surgery, to discuss their individual treatment and any concerns they may have. They also meet the surgeon again on the day of surgery to complete the consent process for surgery.

Patients are provided with written information on the specific procedure to be provided that explains the risks, complications and expected outcomes of the treatment. Patients are also provided with clear post-operative instructions along with contact details if they experience any concerns. Arrangements are in place to review the patient following surgery.

A number of patient care records reviewed were found to be well documented, contemporaneous and clearly outlined the patient journey. It was determined that appropriate arrangements were in place to ensure patients have a planned programme of care and have sufficient information to consent to treatment.

It was confirmed that laser Capsulotomy procedures are only carried out by one of five consultant ophthalmologists, acting as the clinical authorised operators for the YAG laser, and two consultant vascular surgeons who are authorised to use the Cerelas laser for vascular procedures. A register of clinical authorised operators for the Cerelas laser was in place, maintained and kept up to date. It was noted however, that this register included the clinical authorised operators for the YAG laser. Mr McKenna was advised to implement a separate clinical authorised operator register for each laser in use. Mr McKenna was receptive to this advice and the matter was addressed during the inspection.

KPHNW's LPA completed a risk assessment of the premises and the laser safety arrangements. Mr McKenna was advised to review the recommendations made by the LPA to ensure all matters have been addressed. Mr McKenna gave us assurances this matter would be addressed following the inspection.

It was confirmed that laser vascular and YAG Capsulotomy procedures are undertaken in accordance with medical treatment protocols produced by a named medical practitioner. Advice and guidance was provided to Mr McKenna to develop arrangements to ensure the continuous review of the YAG treatment protocols and that they are signed by the named registered medical practitioner. Mr McKenna addressed these matters during the inspection.

Mr McKenna was advised to ensure all authorised operators sign to confirm that they accept and understand the relevant laser treatment protocols. Mr McKenna gave us assurances this matter would be addressed following the inspection.

Up to date local rules were in place which have been developed by the LPA, and these contained the relevant information pertaining to the laser equipment being used. Arrangements were in place to review the local rules on an annual basis.

The local rules included the following:

- the potential hazards associated with lasers
- controlled and safe access
- authorised operators' responsibilities
- methods of safe working
- safety checks
- personal protective equipment
- prevention of use by unauthorised persons
- adverse incident procedures

When the laser equipment is in use, the safety of all persons in the controlled area is the responsibility of the LPS. KPHNW had an appointed LPS.

A review of training records confirmed that all clinical 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. Records confirming clinical authorised operators had undertaken application training for the YAG laser were not available for review during the inspection. Mr McKenna was advised to ensure that all authorised operators have completed applications training for the equipment in use and that records are maintained. Mr McKenna was receptive to this advice and following the inspection RQIA received confirmation that this matter had been addressed. In addition, Mr McKenna was advised that copies of the training records of the laser safety training for assisting staff, and laser safety awareness training should be added to the laser safety file. Mr McKenna gave us assurances this matter would be addressed following the inspection.

A dedicated laser surgical register for the Cerelas was reviewed and was found to be kept up to date. However, it was noted that the Cerelas laser register also included entries for laser procedures undertaken using the Visulas YAG laser. Mr McKenna was advised to introduce a separate dedicated laser register for the Visulas YAG laser and action was taken during the inspection by McKenna to address this matter.

The laser register in place included:

- the name of the person treated
- the date
- the operator
- the treatment given
- the precise exposure given
- any accidents or adverse incidents

Advice and guidance was provided to Mr McKenna to ensure the laser registers are fully maintained every time the laser is operated.

The identified theatre (controlled area) where the laser equipment is used was found to be safe and controlled to protect other persons while treatment is in progress. It was confirmed that the doors to the controlled area are locked when the laser equipment is in use but can be opened from the outside in the event of an emergency.

Observations of the laser equipment identified that an explanatory label for the Visulas YAG laser was required to be replaced. Advice and guidance was provided to Mr McKenna in this regard and following the inspection, RQIA received confirmation that this matter had been addressed.

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 for 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 identified theatre when the laser equipment is in use and turned off when not in use, as described within the local rules.

Arrangements have been established for equipment to be serviced and maintained in line with the manufacturers' guidance. The most recent service report for the Cerelas laser was reviewed. The service report for the Visulas YAG laser was not available for review during the inspection and this matter was discussed with Mr McKenna. Following the inspection, RQIA received a copy of the service report for this laser.

Carbon dioxide (CO2) fire extinguishers, suitable for electrical fires were available in the clinic and arrangements were in place to ensure that the fire extinguishers are serviced, in keeping with manufacturer's instruction.

As a result of the actions taken during and following the inspection, it was determined that appropriate arrangements were in place to operate the laser equipment.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been identified where action is required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments (July 2014).

	Regulations	Standards
Total number of Areas for Improvement	0	1

The area for improvement and details of the QIP were discussed with Mr Mark Regan, Responsible Individual and Mr Anthony McKenna, Registered Manager, as part of the inspection process. The timescale for completion commences from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments (July 2014)	
Area for improvement 1 **Ref:** Standard 32.5 **Stated:** First time **To be completed by:** 20 May 2025	The responsible individual shall ensure scheduling of patients for surgical procedures takes into account the patient requirements for the entire patient pathway, staffing levels, the nature of the surgical procedure, facilities and equipment available and any associated risks. The scheduling must have meaningful involvement of the medical and nursing staff. Ref 5.2.4

	Response by responsible individual detailing the actions taken: Patient Pathway: Kingsbridge Healthcare Group has a robust patient pathway procedure as noted above in the body of the inspection report. From the receipt of referral to post operative care, surgical patients are assessed as to their requirements and suitablility for care within KHG both medically and socially. Where required patients will also receive a pre operative assessment carried out by a Consultant Anaesthetist. This assessment also involves input from the various other diciplines within the hospital when required. Staffing Levels: KHG operates a 3:1 ward nursing ratio for all inpatient procedures well byond the recommended levels provided in national guidance. Our operating theatres are staffed appropriately and according to the clinical complexity of each case. The team is led by a theatre manager, 3 deputies and a number of senior nurses throguhout the department. Each theatre list is also allocated a team leader to coordinate with the ward and other departments where required. No theatre procedure can commence without the appropriate kit equipment and faclilites being in place as is standard practice. Scheduling: We have, as noted above in the body of the inspection report, instigated a weekly theatre planning meeting. This has been expanded to include staff from all areas both at senior and junior level. The upcoming lists are discussed in detail and checks made at that time that all required provisions are in place. This meeting includes input from theatres, recovery, nursing ward, pharmacy, physiotherapy and any other department such as radiology if required. There is also an internal communication system to allow any updates or changes to be communicated across the teams in live time. This ensures that for the safe scheduling of patients appropriate staffing considerations are accounted for, required equipment is available, and that there is an appropriate discharge plan envisioned for the aftercare of each patient. Our services here at Kingsbridge are all Consultant Led during which we work with each consultant to tailor their operating lists to their preference working closely to ensure safety is always at the forefront. We have again reached out to all Consultants to discuss their admission preferences, and order of their lists. The safety of our patients is paramount, this starts from patient selection right through to scheduling, operating, and discharge. With the above procedures in place we are confident that the noted area for improvement has been addressed.

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

Appendix 1

Laser Protection Report

Site Details:
Kingsbridge Private Hospital North West
Church Hill House
Main St
Ballykelly
Limavady
BT49 9HS

Laser Protection Adviser appointed by site:
Phil Loan, One Photon Ltd

Laser/IPL Equipment:

Make	Model	Class	Serial Number	Wavelength(s)
Ceram Optec Bioletic	Cerelas E	4	4291-G	1470 ± 30nm
Zeiss	Visulas YAG III	4	1272074	1064nm

Introduction

A Laser Protection Adviser (LPA) inspection of Kingsbridge Private Hospital North West was performed on 19 March 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. **YAG Laser Explanatory Label:**
The laser explanatory label attached to the laser that details the laser classification, wavelength, and energy output was damaged and only partially legible. A replacement explanatory label should be requested from the laser supplier.

2. **Laser Treatment Protocols:**
- YAG Laser Treatment Protocol; The treatment protocol should be signed by the named registered medical practitioner, and a system put in place to ensure continuous review of the treatment protocol.
- Authorised users; Authorised users should sign to indicate they accept and understand the relevant laser treatment protocol.

3. **Laser Treatment Register**:
- The YAG laser treatment records had been input into the laser register used for the EVLT laser. The clinic should create a separate register for the YAG laser, that follows the relevant heading in standard 48.9 of the minimum care Standards for Independent Healthcare Establishments
- The clinic should ensure that all records in the laser treatment register are correctly completed each time and recorded in chronological order.

4. **Authorised User Register:** Although the authorised users for the new YAG laser had been added to the register, the register was for the EVLT laser. The clinic should ensure that the authorised user register clearly indicates which laser the users are authorised to use.

5. **Training Records:**
- YAG laser Authorised Users; There were no application training records available for the authorised users of the YAG laser. The clinic should ensure all authorised users have completed applications training and records are maintained.
- Laser safety training; Copies of the training records of the laser safety training for assisting staff, and laser safety awareness training should be added to the laser safety file.

6. **Local Rules:**
- The section in the local notes detailing the relevant markings on the clinic's eyewear for the YAG laser does not include the wavelength markings. This is most likely a typographical error and the clinic should ask the LPA to update this.
- The clinic should ensure that all authorised users have signed to confirm they accept the local rules.

7. **Risk Assessment and LPA Report:** The clinic should implement the recommended actions in the risk assessment and LPA's report, and ensure they are signed off on completion.

8. **Policy – Use of Lasers within KPHNW:** Large sections of this document are a duplicate of the Local Rules. The clinic should seek advice from their LPA to amend this document to provide an overarching statement on the approach to laser safety, making reference to the existence of Local Rules and Treatment Protocols.

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

Mrs Jane Brown
Laser Protection Adviser to RQIA

Post Inspection Update: The clinic provided an update following the LPA inspection visit on the 19 March 2025 demonstrating that they were following up on the points discussed.

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