The Regulation and Quality Improvement Authority

Inspection Report

8 and 9 October 2025

Ulster Independent Clinic

Type of service: Independent Hospital
Address: 245 Stranmillis Road, Belfast, BT9 5JH
Telephone number: 028 9066 1212

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

1.0 Service information

Organisation/Registered Provider: Ulster Independent Clinic Limited **Responsible Individual:** Ms Diane Graham	**Registered Manager:** Ms Diane Graham **Date registered:** 11 April 2007
Person in charge at the time of inspection: Ms Diane Graham	**Number of registered places:** 70
Categories of care: Independent Hospital (IH) Acute Hospital Inpatient (AH) Acute Hospital Day surgery – (AH-DS) Private Doctors (PD) Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers - PT (L) Prescribed techniques or prescribed technology: establishments using endoscopy - PT (E)	
Brief description of the accommodation/how the service operates: The Ulster Independent Clinic (UIC) provides a wide range of surgical, medical and outpatient services for both adults and children. The hospital is registered to accommodate up to 70 patients as in-patients or day surgery cases. The hospital has eight theatres along with recovery units; a dedicated endoscopy suite; a one stop breast care clinic; a limited chemotherapy service; an x-ray department and magnetic resonance imaging (MRI) scanning; a urology surgical laser service; a pathology laboratory; and a range of consulting rooms. The in-patient and day surgery accommodation comprises of single en-suite rooms which are situated over two floors. The hospital also operates a Hospital Decontamination and Sterilisation Unit (HDSU) used to decontaminate equipment for use within the hospital.	

2.0 Inspection summary

A short notice announced inspection was undertaken to the UIC on 8 and 9 October 2025 by a RQIA multi-disciplinary inspection team.

RQIA's Laser Protection Advisor (LPA) accompanied the inspectors and reviewed the laser equipment and the laser safety arrangements. Their findings and recommendations are appended to this report.

Feedback of the inspection findings was delivered to the UIC management upon conclusion of the inspection.

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

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.

Three areas for improvement were identified during the inspection. One area for improvement was identified against the regulations, relating to the review of governance and oversight arrangements for the laser service. Two areas for improvement were identified against the standards; one to ensure that relevant staff read and sign the laser manual, and one to ensure all relevant support staff have up to date laser safety training, commensurate with their roles.

No concerns were identified in relation to patient safety and the inspection team noted areas of strength, particularly in relation to the delivery of front line care.

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 and quality improvement plan (QIP).

Some of inspection team undertook a tour of the premises and the inspection was facilitated by Ms Graham and other staff members.

The inspection team spoke with; Ms Graham; the quality and education team; the theatre manager; the recovery sister; the senior nurse recovery; two recovery nurses; the Hospital Decontamination Sterilisation Unit (HDSU) manager; the HDSU supervisor; the resuscitation officer; the residential medical officer; an inpatient unit ward sister, ward based nursing staff, members of the hospital liaison team, treatment room nursing staff and the outpatient unit sister.

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 UIC by RQIA prior to the inspection, inviting patients and staff to complete an electronic questionnaire.

One staff member submitted a questionnaire response. The response indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. The staff member indicated that they were very satisfied with each of these areas of patient care. The staff response included a positive comment pertaining to the safety and cleanliness of the establishment.

No completed patient questionnaires were received following 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 UIC was undertaken on 20 and 21 November 2024; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Governance and Leadership

Organisational Governance
There was a clearly defined organisational and management structure within the UIC that clearly identifies the lines of accountability, specific roles and responsibilities.

Staff confirmed having positive working relationships with the management team, who were approachable and responsive to their suggestions and concerns. Staff informed us that felt valued, respected and well-supported by their direct managers and the senior management team.

Established systems were in place to ensure effective communication with all staff. This included regular team meetings, targeted emails, learning boards and a bi-monthly governance newsletter.

The Competition and Markets Authority (CMA) mandates that private hospitals and consultants submit data to the Private Healthcare Information Network (PHIN) as the Information Organisation for private healthcare. This provides individuals considering private healthcare with the information they need to make an informed choice of which consultant and hospital is right for them.

The UIC has implemented an electronic system for collecting patient experience feedback, which enables them to submit data to PHIN. Patient feedback was shared with staff to inform service improvement and drive ongoing quality enhancements.

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

The UIC's Clinical and Quality Governance Strategy provides a clear framework for improving quality. It promotes accountability, transparency and ongoing improvement with a focus on patient safety and staff development. By engaging stakeholders and setting measurable goals, the strategy supports the delivery of safe and high quality care.

Effective systems and governance structures were in place. Regular meetings were held by key committees, including the Clinical Governance Committee (CGC), Medical Advisory Committee (MAC) and the Practice Development Group, ensuring effective oversight and decision making.

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

Systems were in place to ensure that the quality of services provided by the UIC is evaluated on an ongoing basis. A range of audits are conducted regularly, with findings used to inform practice and drive improvement. Identified actions are implemented, ensuring lessons are learnt and quality of care is enhanced.

Clinical and Medical Governance

Over 300 consultant specialists work in the hospital. The UIC's 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 UIC's practising privileges conditions of membership.

The CGC meet on a monthly basis, with the function of assisting the Board in its oversight and integrity of UIC's clinical governance arrangements, including responsibilities regarding RQIA, the PHIN and Caspe Healthcare Knowledge Systems (CHKS).

The duties of the CGC 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 CGC will identify areas appropriate for medical audit and will oversee these audits and outcomes.

The collaboration between CGC and the MAC facilitates constructive discussion and feedback from diverse perspectives on key governance matters.

The MAC meet at least quarterly with responsibility for medical practitioner performance and surgery specific matters. As discussed the CGC ensures all the documentation for consultants with practising privileges are in place including checking registration with the GMC, professional indemnity and appraisals. Terms of reference and Standing Orders for the MAC were in place which were ratified in 2023 and these have been developed in accordance with Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments (2014). Ms Graham as the chief executive officer of UIC also attends these meetings. 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 the MAC meeting minutes confirmed that these meetings were being undertaken on a quarterly basis in line with the criteria set out in Standard 30.

The MAC also issue the 'MAC News' to consultants with information regarding maintenance of practising privileges and annual appraisal documentation, clinical audit outcomes, policy and procedure updates, theatre management arrangements and a summary of the most recent medical and drug safety alerts issued. Consultants are also reminded that any change to their scope of practice or an investigation into any aspect of their practice or any other institution (HSC or Independent Sector) must be immediately communicated to the chair of the governance committee and Ms Graham. An example of a recent topic addressed in 'MAC News' concerned consultant coverage for difficult to contact consultants, which occurs infrequently. The discussion focused on establishing a defined agreement for such coverage and promoting a collaborative team approach to its provision.

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.

A comprehensive process exists for the revalidation of wholly private doctors, incorporating face-to-face meetings to review required appraisals and other pertinent information prior to making a revalidation recommendation.

Experienced senior doctors work as Responsible Officers (ROs) with the GMC to make sure doctors are reviewing their work. As part of the revalidation process, ROs make a revalidation recommendation to the GMC. It was established that UIC 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 consultant's 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

Ms Graham outlined the clinical governance over-sight arrangements in place for UIC. It was established that all consultants who work in UIC are not directly employed and work under a practising privileges agreement.

We reviewed the arrangements for the oversight and recording of induction and on-going training for consultants to ensure all consultants working in UIC receive mandatory training and other training, supervision and appraisal in accordance with best practice guidance. It was confirmed that records of induction or records to evidence ongoing training provided by UIC, were in place for staff who are not directly employed by UIC.

A review of records demonstrated that the clinic retains a copy of each consultant's annual appraisal document. 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 tracking system was in place which recorded when appraisals have been received and if there has been a delay reason and the date the appraisal is expected to be submitted is documented.

All doctors registered with the GMC have to undertake a whole practice appraisal. Accordingly the UIC provides letters of good standing which include information on clinical outcomes, complaints and Serious Adverse Incidents (SAIs) examples of which were reviewed. The recent appointment of a Medical Director is regarded as a constructive measure towards strengthening clinical leadership and governance, thereby ensuring the provision of high-quality, safe patient care.

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 Graham informed us that that all medical practitioners (consultants) who work in UIC 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.
Information on the requirements for practising privileges is available and easy to access under governance on the organisation's website.

A review of the practising privileges agreement confirmed that there is clear and accurate information on when annual appraisals should be submitted and clear escalation actions are outlined if annual appraisals are not submitted within the specified time. This also includes the consequences should annual appraisals not be submitted, the timeframes and any assurances that may be sought to confirm the practitioner can continue to work in the clinic.

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).

The induction process for 'new' consultants at UIC is conducted by Ms Graham prior to granting of practising privileges. According to the RO and Medical Director (MD) this is a thorough process. The Medical Director has indicated an interest in attending future induction sessions, believing this would be of benefit prior to granting practising privileges.

An electronic system is in place which clearly shows the status of all practising privileges agreements; this is colour coded to identify those agreements that had been reviewed within the previous two years; those that are due for renewal with a reminder issued to the consultant and those that are temporarily suspended due to information not being provided by the consultant.

A review of a sample of records evidenced that there was a written practicing privileges agreement between each consultant and the UIC setting out the terms and conditions, and the consultant's scope of practice and had been signed by both parties.

As previously discussed, practising privileges matters are discussed and reviewed biannually during the MAC meetings; however an annual review may be conducted if concerns arise regarding a medical practitioner.

Any concerns raised by the HSC regarding doctors working at either the UIC or reciprocally are formally communicated between Responsible Officers (ROs). The UIC RO will then inform Ms Graham of any issues, which are subsequently addressed during the CGC and MAC meeting.

Discussion with Ms Graham demonstrated effective oversight of the granting of practicing privileges, with appropriate agreements in place providing assurance of robust medical governance arrangements within the organisation.

Quality Assurance

Review of UICs quality assurance processes demonstrated a robust framework in place to drive quality improvement. Regular audits, reviews and monitoring activities were conducted across the different departments, with findings used to drive improvement and inform practice.

Effective governance structures, including regular committee meetings and clear reporting lines, supported oversight and accountability for quality assurance. Review of policies and discussions with staff identified a culture of transparency and openness, where staff felt empowered to report concerns and suggest improvements and therefore contributing to ongoing quality improvement.

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

A policy and procedure was in place in relation to managing and reporting of clinical risks, incidents and near misses. This policy which was reviewed in July 2025 outlined the roles and responsibilities for the management of all notifiable events. A new incident management system has been implemented from January 2025 to support learning and improvement, with a systematic analysis of incidents being used to identify trends and weaknesses.

All clinical incidents are reviewed by CGC and MAC and any necessary actions agreed.

Discussion with staff and a review of records confirmed a robust governance and oversight system in place to ensure all incidents were thoroughly investigated, and that lessons learned were shared with staff to drive continuous improvement.

Complaints Management

The complaints policy and procedure provided clear instructions for patients and staff to follow. Patients and/or their representatives were informed of the complaints process through the patients guide. The complaints policy and procedure was found to be in line with the relevant legislation. Discussion with Ms Graham confirmed that arrangements are in place to update the policy, incorporating the new Model Complaints Handling Process (MCHP), published in July 2025, with implementation planned by 1 January 2026.

Review of records and discussion with Ms Graham evidenced good governance and robust processes in relation to the management of complaints. Complaints are not only addressed on an individual basis but are also used to identify trends and inform service improvements. Furthermore, complaints are utilised for learning purposes, enabling management and staff to reflect on service delivery and make necessary adjustments to enhance patient care and experience. This proactive approach to complaint management promotes a culture of transparency, accountability, and continuous quality improvement.

Overall, the governance structures within the hospital provided the required level of assurance to the UIC board.

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

The arrangements for the recruitment and selection of staff was reviewed. The review of staff personnel files, and the recruitment policy and procedures confirmed in the main effective systems were in place to ensure the safe recruitment of staff. However, it was found that a number of surgical assistants who only provide support for the Health Social Care (HSC) patients within UIC had not been fully subject to UICs recruitment process and the appropriate practising privileges arrangements. This area is further discussed in section 5.2.3.

Discussions with staff, review of the staff register and duty rotas evidenced that there were sufficient numbers of staff in various roles to fulfil the needs of the hospital and patients.

Newly appointed staff complete a competency based induction program to ensure they are fully skilled, knowledgeable and equipped within their job roles.

The program covers key policy and procedures and role specific training to ensure consistency and standards are maintained across the hospital. In addition to this, staff received ongoing supervision and support to review their progress and maintain continued professional development.

There are clear arrangements in place for resident medical cover at UIC through the role of the Resident Medical Officer (RMO) who are employed through NES Healthcare. NES Healthcare provides all necessary training and oversees the appraisal and revalidation responsibilities for RMOs. A robust training matrix was in place and reviewed at inspection which evidenced high compliance levels in all aspects of mandatory training. The matrix is overseen by the quality and education team and shared monthly with all departments. During a review of the laser service it was noted that some staff had not completed laser safety training within the last five years. This area is further discussed in section 5.2.6.

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

Discussions with the Quality and Education Team, and a review of records confirmed that a clear system was in place to ensure the registration details of health and social care professionals are regularly reviewed and verified with their respective professional bodies. The hospital has robust systems and oversight mechanisms in place to maintain accurate and up to date registration information.

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

5.2.3 Are there safe practices in place for the day surgery/endoscopy services?

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

There are eight theatres, four of which have laminar airflow ventilation. Robotic assisted surgery takes place in theatre four. There are three post-operative recovery areas adjacent to the theatre suites.

It was confirmed that adult and limited paediatric surgical services are provided. The scheduling of patients for surgical procedures is co-ordinated by the administration office, senior management and the theatre manager. The theatre lists 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.

The patient will be sent information about the procedure and any preparation necessary in advance. The consent process is completed by the consultant carrying out the procedure as part of the admission process. Review of the consent policy noted that details of the Mental Health Capacity Act 2016 was not reflected in the policy. Management gave assurances that this matter would be fully addressed.

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

It was confirmed that patients are observed during and after the surgery or endoscopy procedures by appropriately trained staff. Surgery 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 overall well recorded in accordance with regulation. It was confirmed surgical assistants are used in the hospital and a log/database is maintained of their participation in surgery. It was noted the full names and specific designations of the surgical assistants was not always fully recorded in all the necessary documentation. Most surgical assistants have practising privileges with the hospital and operate within a defined scope of practice. Others are employed by the hospital as 'bank' staff. However, a number of surgical assistants who provide support for Health Social Care / Trust only patient theatre lists in UIC had not been fully subject to the recruitment process and appropriate practising privileges arrangements. Management outlined that this had been a legacy position dating from agreed arrangements during the Covid pandemic. It was advised that these arrangements are no longer appropriate and all staff providing services require to be recruited in line with legislation; and either be employed or have practising privileges in place. A complete database of surgical assistants should be made available to theatre staff. Advice and guidance was provided to management and following inspection, RQIA received confirmation that this matter had been addressed.

UIC has an EN ISO 13485 certified Hospital Sterilisation and Decontamination Unit (HSDU) on site. The HSDU supplies sterile instrument packs and reprocessed endoscopes for surgical and endoscopy 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. It was advised to consider devising a skin prep procedure including drying time, who is responsible for ensuring adherence to the procedure and ensuring that adherence to the procedure is reflected in the patient record. Advice and guidance was provided to management and following inspection, RQIA received confirmation that this matter had been addressed.

The inspectors reviewed a detailed handwritten information book on orthopaedic surgical procedures. Theatre management confirmed it was a very valuable resource. However, the governance and oversight of this document was not in line with the hospital's robust ratification process. Advice and guidance was provided to management and following inspection, RQIA received confirmation that this matter had been addressed.

There is an accredited pathology laboratory on site which is subject to internal audit. Most pathology services are provided on site, however if further pathology investigations are required there is a contract in place for additional external pathology services.
There were procedures for the collection, labelling, storage, preservation, transport and administration of specimens, and procedures for reporting results to the appropriate clinical staff and GP's. A review of a specimen log book held in a theatre noted that individual dates were not always outlined for each entry for the purpose of completeness. Advice and guidance was

provided to management, including auditing the specimen log book within the audit programme. Following inspection RQIA received confirmation that this matter had been addressed.

Emergency trollies are located adjacent to theatres and checked daily by nursing staff. Emergency medicines, oxygen and equipment were all 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. Theatre management confirmed massive blood loss drills have taken place and that an update is to be arranged in the near future. There was a separate massive blood loss tray and a relevant documentation folder in place.

Theatre management confirmed that joint replacement information is provided for the National Joint Registry with the consent of patients. Ms Graham confirmed that work is advanced to ensure hospital participation in the Breast and Cosmetic Implant Registry and support had been sought from the external advice sources. However, despite these efforts it has not yet been implemented. It was advised to ensure this work is completed as a priority and hospital participation is established for the Breast and Cosmetic Implant Registry. Ms Graham gave assurances on this matter.

It was determined that safe practices are in place for the delivery of surgery and endoscopy services.

5.2.4 Are there safe practices in place for the inpatient services?

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

It was confirmed that patients are admitted by way of referral from a general practitioner (GP), sports bodies, health board contracts or self-referral, and must be arranged by a consultant.

It was confirmed that patients are reviewed by a consultant, anaesthetist and pre-operative assessment 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.

The inpatient unit is divided into two levels, level one for day surgery patients and level two for patients requiring to stay overnight. In the inpatient 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.

Discussion with staff confirmed that on admission to the inpatient unit, a holistic assessment of patient's care needs and a range of risk assessments are carried out. It was confirmed that arrangements are in place to refer patients to members of the multi-disciplinary team if required. Discussion with staff confirmed that care plans and ongoing care needs are discussed and agreed with the patient and also the multidisciplinary team. It was also confirmed that care plans are reviewed with the patient in keeping with their changing needs.
It was evidenced that care is delivered in a co-ordinated way between the inpatient wards and theatres area, creating an efficient patient flow though the service.

Staff were observed to be compassionate and positive interactions were observed between staff and patients as staff entered and exited patient's rooms.

Discussion with staff confirmed that a wide choice of nutritious meals were offered that included specific meals for patients requiring specialised diets, and meal times that were flexible and individually tailored according to the patient's wishes and needs. Nursing staff confirmed that they would contact the patient's speech and language therapist (SALT) for further advice regarding any specialised dietary descriptors as outlined within the International Dysphagia Diet Standardisation Initiative (IDDSI), if required.

Discussion with staff confirmed that pain was assessed daily and prior to routine practices being performed for example: wound dressing and movement. It was also confirmed that medical staff were readily available if further pain relief prescriptions were required. Discussion with staff confirmed that pain medication is administered as prescribed in the medicine kardex and arrangements are in place for pain relief to be prescribed out of hours, if required. Staff confirmed they are adequately trained in medicines management and are competent in the administration of controlled drugs.

The management of wound and pressure area care was discussed and it was confirmed that various wound and pressure area care assessment tools were in place. Discussion with staff confirmed that staff assist patients to reposition when required and that various pressure relieving devices are available. It was confirmed that patients can be referred to the tissue viability nurse if required. Staff had a sound knowledge of wound management and the use of aseptic non-touch technique (ANTT).

The role of the hospital liaison sister (HLS) was reviewed. The HLS reviews patients following surgery and provides information regarding the discharge arrangements. 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 also confirmed 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 matters required further attention. This matter was discussed with Ms Graham who provided assurances that these matter would be reviewed.

During a tour of some areas of the inpatient units, clinical areas were observed to be clean, tidy and uncluttered, with hand hygiene facilities available throughout. All observed areas were appropriately equipped to meet patient's needs.

It was determined that safe practices are in place for the inpatient unit.

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

There was a medical emergency policy and procedure in place and a review of this evidenced that it reflected legislation and best practice guidance.

Systems were in place to ensure that emergency medicines and equipment are immediately available and do not exceed their expiry dates.

An emergency trolley containing emergency medicines and equipment is readily accessible within the inpatient unit. Each trolley is checked twice daily by nursing staff. Emergency medicines were stored securely and oxygen was noted to be in date. There was separate adult and paediatric emergency medicines and equipment in place.

Relevant staff were able to describe the actions they would take in the event of a medical emergency and were familiar with the location of medical emergency medicines and equipment.

It was determined that the service had appropriate arrangements in place to manage a medical emergency.

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

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

The laser service is provided in a theatre suite and the laser procedures are carried out by seven consultant urologists acting as clinical authorised operators. The consultants are assisted by nursing staff acting as non-clinical authorised operators. A register of authorised operators for the laser equipment is maintained. It was identified that anaesthetists and radiographers can also be present during the use of the laser in theatre.

A laser manual is maintained and a review of this found that it contained all of the relevant information required with regards to the laser equipment in use. A review of the laser manual signature sheet identified that all consultant urologists had signed to confirm they had read and understood the laser information retained. However, it was found that signatures were not present for a number non-clinical authorised operators who work in the theatre suite. The LPS should ensure that all non-clinical authorised operators read and sign the laser manual as a matter of priority. An area for improvement has been made against the standards in this regard.

There was written confirmation of the appointment and duties of a certified LPA which is reviewed on an annual basis. The service level agreement between the clinic and the LPA had been reviewed and is due to expire in 2030.

The LPS confirmed that a new laser had been installed for use in theatre during June 2025. The appointed LPA had completed a risk assessment of the premises during August 2025, prior to the commissioning of the laser into clinical service. A review of the report confirmed that recommendations made had been fully addressed by the LPS.

It was confirmed that laser surgical procedures are undertaken by the consultant urologists in accordance with medical treatment protocols. The protocols are produced by one of the consultant urologists and systems were in place to review these protocols on an annual basis. A review of the protocols identified that a number of consultants had yet to sign to acknowledge the protocol and this was brought to the attention of the LPS, who gave assurances that this matter would be addressed.

Up to date local rules were in place which have been developed by the LPA and these were reviewed in February 2025.

Review of the local rules confirmed that all the required information was included as follows:

- 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

The LPS is aware that when the laser equipment is in use, the safety of all persons in the controlled area is their responsibility. There were arrangements in place for another authorised operator to deputise for the LPS, when required, and it was confirmed that they were suitably trained to fulfil the role.

It was confirmed that the laser surgical register is maintained every time the laser is operated and included:

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

A review of the laser surgical register found that the above details were documented consistently and accurately. It was noted that the register included the names of the anaesthetist, and nursing staff present in assistant roles.

The theatre suite where the laser equipment is used was found to be safe and controlled to protect other persons while treatment is in progress.

The laser is operated using a key that unauthorised staff do not have access to and there were arrangements in place in relation to the safe custody of the key for the laser equipment.

Protective eyewear was available for authorised operators and laser assistants when required. A review of the eyewear inventory within the local rules identified that it required further development to fully reflect details of all protective eyewear available for clinical use in theatre. This was discussed with the LPS who gave assurances that this matter would be followed up with the LPA.
The laser safety warning signs are displayed and also illuminated outside of the laser suite when the laser is in use. The illuminated light is turned off when the laser is not in use, as described within the local rules.

Arrangements have been established for the laser equipment to be serviced and maintained in line with the manufacturer's guidance.

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

As stated previously the LPA for RQIA also reviewed the safe use of the laser equipment currently in use. Their findings and laser safety report are appended to this report.

Evidence of training undertaken was retained within the laser manual.

A review of records for the seven clinical authorised operators evidenced that they all have up to date training in the Core of Knowledge, and have undertaken equipment based training for the new laser.

As discussed previously, the consultant urologist works in theatre alongside nursing staff, listed as non-clinical authorised operators. Records pertaining to laser safety awareness training were reviewed with respect to this staff group and it was identified that not all staff had completed this training.

The LPS informed RQIA that a number of staff had recently attended an LPA-led laser safety training session and provided assurances that arrangements were being put in place for the LPS to cascade training to relevant nursing staff, radiographers and anaesthetists moving forward. Advice and guidance was provided to the LPS to perform a training needs analysis to identify and document all staff required to complete laser safety training, commensurate with their role. Evidence of completed training is to be retained and made available for inspection. An area for improvement has been made against the standards in this regard.

In light of the issues identified at this inspection and also taking into consideration recommendations made at previous inspections, it is determined that the governance and oversight arrangements of the laser service at UIC require strengthening with respect to staff training and governance. It was suggested that assurance and auditing systems are put in place to document and effectively monitor compliance with training which will in turn inform skill-mix and workforce needs. Clear lines of responsibility, and processes should be defined with respect to same. An area for improvement has been made against the regulations in this regard.

Addressing the stated areas for improvement will ensure laser safety arrangements within UIC comply with the legislation, best practice guidance and RQIA training guidance.

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	1	2

Areas for improvement and details of the QIP were discussed with Ms Graham, the quality and education team and the LPS, 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 17 (1) **Stated:** First time **To be completed by:** 31 December 2025	The responsible individual shall review the governance and oversight arrangements of the laser service to ensure compliance with all regulations, minimum standards and best practice relating to laser safety. Ref: 5.2.6
	Response by registered person detailing the actions taken: Following a review of governance for the laser service and using RQIA LPA report the following have been actioned. 1. Documentation has been reviewed and updated with the serial number of the new laser. 2. Staff have been reminded at a meeting on 13 October 2026 to have the 'laser in use' sign illuminated only when the laser is being used. 3. Revised Local Rules have been circulated electronically to all theatre staff, radiographers, Consultant anaesthetists and surgeons involved in laser procedures incorporating a read and signature function. A separate laser training matrix has been developed to include a record of Core of Knowledge training, equipment training, laser safety awareness training and receipt of local rules. This reflects the required training for all clinical and non-clinical roles The UIC 's LPS and Q&E department have developed an e-learning module on laser safety awareness which is available on the UIC's training platform for all relevant staff with records of completion retained. 4. The Medical Treatment Protocol has been signed by all Consultant Urologists using the laser to indicate they accept and understand the protocol.

Action required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments (July 2014)	
Area for improvement 1 **Ref:** Standard 48.6 **Stated:** First time **To be completed by:** 31 December 2025	The responsible individual shall ensure arrangements are in place that ensure all relevant staff read and sign the laser safety manual in a timely manner. All non-clinical authorised operators should read and sign the laser manual as a matter of priority. Evidence of this should be submitted on return of the QIP. Ref: 5.2.6
	Response by registered person detailing the actions taken: A separate laser training matrix has been developed to include a record of Core of Knowledge training, equipment training, laser safety awareness training and receipt of local rules. Compliance for reading and signing Local Rules is currently 82%
Area for improvement 2 **Ref:** Standard 48.13 **Stated:** First time **To be completed by:** 31 December 2025	The responsible individual shall ensure all relevant support staff have up to date training in laser safety, commensurate with their roles, and evidence of this should be retained within the laser manual and made available for inspection. Evidence of this should be submitted on return of the QIP. Ref: 5.2.6
	Response by registered person detailing the actions taken: A separate laser training matrix has been developed to include a record of Core of Knowledge training, equipment training, laser safety awareness training and receipt of local rules. Compliance for laser safety training is currently 88%

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

Appendix 1

23 October 2025

Laser Protection Report

Site Details:
Ulster Independent Clinic
245 Stranmillis Road
Belfast
BT9 5JH

Laser Protection Adviser appointed by site:
Philip Loan, One Photon

Laser/IPL Equipment:

Make	Model	Class	Serial Number	Wavelength(s)
Quanta System	Litho Evo	4	LHV1008-0324	2100nm (Ho:YAG)

Introduction

A Laser Protection Adviser (LPA) inspection of Ulster Independent Clinic was performed on 8 October 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. **New Laser**
   The laser had been recently replaced and whilst the laser documentation had been updated to reflect this, it was noted that the laser serial number was incorrect on the following documents:

   - Equipment Inventory
   - Use of Lasers in Theatres

   The above documents should be updated with the serial number of the new laser.

2. **Laser Controlled Area:**
   On the day of the inspection it was noted that the illuminated laser in use sign for Theatre 2 was switched on, however there was no laser procedure taking place.

   The clinic should ensure that all staff working in theatres are aware of the significance of the laser signs and that laser signs should only be illuminated when the laser is in use.

3. **Local Rules and Training Records:**

   The following points relating to the local rules & training records require remedial action:

   A. <u>Local Rules Signatures</u>

   The updated local rules had not been signed by all staff recorded as assisting in laser procedures including some nursing staff, radiographers and anaesthetists. The clinic should ensure that all staff assisting in laser procedures have read and signed the local rules.

   B. <u>Training Matrix</u>

   - There was a discrepancy between staff who had signed laser local rules and staff training records. Whilst not a regulatory requirement, it is good practice to have a training matrix for laser staff to provide a clear overview of training required for each staff member and training completed. This will make it easier for staff preparing duty rotas to ensure only staff who have completed laser training and read the local rules are assigned to laser cases.

   C. <u>Assisting Staff</u>

   - Laser equipment training - some assisting staff had not completed laser equipment training, however the LPS indicated this process was ongoing for the new laser.
   - Laser safety training – Laser safety awareness training was being held on the day of inspection for assisting staff. The Laser Protection Supervisor indicated that following on from this she would cascade this training to any staff who were unable to attend.

   The clinic should ensure that training for all laser staff is up to date and training records are maintained.

4. Medical Treatment Protocol:

With the exception of the Consultant who authorised the Medical Treatment Protocol, the authorised laser users have not signed to indicate that they accept and understand the medical treatment protocol.

In accordance with Standard 48.6 of the Minimum Care Standards, the clinic should ensure that all authorised users have signed to indicate that they accept and understand the medical treatment protocol.

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

Mrs Jane Brown
Laser Protection Adviser to RQIA

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews