The Regulation and Quality Improvement Authority

Inspection Report

15 December 2025

Marlborough Clinic Belfast Limited

Type of service: Independent Hospital
Address: 1 Marlborough Park, Belfast, BT9 6XS
Telephone number: 028 9002 2000

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/, The Independent Health Care Regulations (Northern Ireland) 2005 and the Minimum Standards for Dental Care and Treatment (March 2011)

1.0 Service information

Organisation/Registered Provider: Marlborough Clinic Belfast Ltd **Responsible Individual:** Mrs Brenda Nelson	**Registered Manager:** Mrs Brenda Nelson **Date registered:** 25 January 2023
Person in charge at the time of inspection: Mrs Brenda Nelson	**Number of registered places:** Six
Categories of care: Dental Treatment Acute hospital – day surgery AH (DS) Private Doctor (PD) added following this inspection.	
Brief description of how the service operates: Marlborough Clinic Belfast Limited is registered with RQIA as an independent hospital with six registered dental surgeries, providing private dental care and treatment and offers conscious sedation, if clinically indicated. In addition the establishment is also registered with an Acute Hospital (Day Surgery) category of care. A variation to registration application was submitted to RQIA on 7 November 2025 to add a Private Doctor (PD) category of care. This application also included two additional treatment rooms.	

2.0 Inspection summary

This was an announced combined variation to registration and primary inspection undertaken by two care inspectors on 15 December 2025.

It focused on the themes for the 2025/26 inspection year and assessed progress with any areas for improvement identified during and since the last care inspection.

This inspection also sought to review the readiness of the establishment for the addition of a Private Doctor (PD) category of care and two additional treatment rooms, as outlined in the variation to registration application submitted to RQIA.

An RQIA estates officer reviewed the variation to registration application in regard to matters relating to the premises and has approved the variation to registration application from an estates perspective.

There was evidence of good practice in relation to the recruitment and selection of staff; staff training; management of medical emergencies; management of conscious sedation (dental patients); infection prevention and control (IPC); decontamination of reusable dental instruments; radiology and radiation safety; management of complaints and incidents; records management; and governance arrangements.

Examples of good practice were evidenced in patient safety in respect of the management of the patients' care pathway; ensuring the core values of privacy and dignity were upheld and engagement to enhance the patients' experience.

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.

Information has been gathered through the inspection process. Scrutiny of this information means that the variation to registration application is approved from a care perspective.

3.0 How we inspect

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

The information obtained is then considered before a determination is made on whether the practice is operating in accordance with the relevant legislation and minimum standards.

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

- the registration status of the hospital
- written and verbal communication received since the previous care inspection
- the variation to registration application
- the updated statement of purpose
- the updated patient guide

During the inspection a tour of the premises was undertaken and the inspector met with Mrs Brenda Nelson, Registered Manager and members of the dental and medical teams.

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

4.0 What people told us about the care and treatment?

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

No patient questionnaires were received prior to the inspection.

Twenty staff submitted questionnaire responses. Staff responses indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. Staff indicated that they were either satisfied or very satisfied with each of these areas of patient care. A level of dissatisfaction was noted by one respondent, however no comment was left. Eight staff responses included positive comments in regards to the management, support and working environment and patient care provided.

5.0 The inspection

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

The last inspection to Marlborough Clinic Belfast Limited was undertaken on 4 October 2024; no areas for improvement were identified.

5.2 Inspection findings

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

A review of the statement of purpose evidenced that it fully reflected the key areas and themes as specified in Regulation 7, Schedule 1 of The Independent Health Care Regulations (Northern Ireland) 2005. The statement of purpose had been updated to reflect the recent extension of services.

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

A review of the patient guide evidenced that it fully reflected the key areas and themes specified in Regulation 8 of The Independent Health Care Regulations (Northern Ireland) 2005. The patient guide had updated to reflect the recent extension of services.

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

Marlborough Clinic Belfast Limited is registered with RQIA as an independent hospital with six registered dental surgeries and provides private dental care and treatment and offers conscious sedation for dental patients, if clinically indicated. In addition the establishment is registered with an Acute Hospital (Day Surgery) category of care. The day surgery service initially provided hair transplant procedures only. This service has been further developed to provide a range of minor day surgery procedures.

The policies and procedures surrounding clinical and organisational governance arrangements were reviewed and discussed with Mrs Nelson. It was demonstrated that there was a clear management structure with defined lines of responsibility and accountability for the range of services provided at the establishment.

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

A range of minutes from governance meetings were made available for review.

Risk management procedures and arrangements for the oversight and management of incidents were reviewed and provided assurance that risks identified with the hospital, including treatment and services provided are identified, assessed and managed appropriately.

A range of policies and procedures were accessible. 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 regular structured staff meetings take place and minutes were available to review.

There was also evidence of patient feedback being shared with staff as a means of continually evaluating and driving service improvement.

Clinical and medical governance

A medical advisory committee (MAC) has been established which meets quarterly. 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, as relevant.

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 General Medical Council (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.

As previously discussed a variation to registration application was submitted to RQIA by Mrs Nelson on behalf of Marlborough Clinic Belfast Ltd to add a Private Doctor (PD) category of care.

One new medical practitioner has been recruited who is considered to be a wholly private doctor as they are GMC registered doctor who does not have a prescribed connection to a Responsible Officer within the Health and Social Care (HSC) sector in Northern Ireland.

A review of the private doctor'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
- up to date annual appraisal by a trained medical appraiser
- an appointed RO
- arrangements for revalidation

Following the inspection additional information was provided to RQIA which confirmed that all required documentation and processes were in place to enable approval of the addition of a private doctor category of care.

The arrangements for oversight and recording of mandatory training and professional development activities of medical practitioners in accordance with best practice guidance was discussed with Mrs Nelson. It was confirmed that there is a requirement for all medical practitioners, working under practicing privileges, to provide evidence of mandatory training. A review of medical practitioner's personnel files confirmed that certificates of mandatory training are retained on file.

Practising Privileges

The only mechanism for a medical practitioner to work in a registered independent hospital is either under a practising privileges agreement or through direct employment by the hospital.

Practising privileges can only be granted or renewed when full and satisfactory information has been sought and retained in respect of each of the records specified in Regulation 19 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended.

A detailed policy and procedure for the granting, review and withdrawal of practicing privileges agreements was in place.

It was confirmed that a practising privileges agreement was in place for each medical practitioner working in the establishment which were found to be in accordance with best practice. Mrs Nelson confirmed that practising privileges agreement are reviewed at least every two years.

Discussion with Mrs Nelson and a review of records demonstrated that 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 all care and treatment delivered to dental and day surgery patients at appropriate intervals.

In respect of hair transplant procedures, a patient monitoring log is maintained in accordance with best practice guidance. The medical practitioner who undertakes hair transplant procedures is responsible for completing this log and auditing on an annual basis. The findings are shared with the MAC and recommendations (if any) agreed.

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.

Complaints and Incident Management

The arrangements for the management of complaints and incidents were reviewed to ensure that they were being managed in keeping with legislation and best practice guidance.

The complaints policy and procedure provided clear instructions for patients and staff to follow. Patients and/or their representatives were made aware of how to make a complaint by way of the patient's guide and information on display in the practice.

Arrangements were in place to record any complaint received in a complaints register and retain all relevant records including details of any investigation undertaken, all communication with complainants, the outcome of the complaint and the complainant's level of satisfaction.

A review of records concerning complaints evidenced that complaints had been managed in accordance with best practice guidance. Mrs Nelson confirmed that arrangements are in place to undertaken a complaints audit to identify trends, drive quality improvement and to enhance service provision.

A policy for the management and reporting of clinical risks, incidents and near misses and a policy for the management of national safety alerts were in place. Mrs Nelson confirmed that incidents are effectively documented and investigated in line with legislation.

All relevant incidents are reported to RQIA and other relevant organisations in accordance with legislation and RQIA Statutory Notification of Incidents and Deaths. Arrangements are in place to audit adverse incidents to identify trends and improve service provided.

Staff spoken with were knowledgeable on how to deal with and respond to complaints and incidents in accordance with legislation, minimum standards and the DoH guidance.

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

As previously mentioned significant incidents and themes reported will be discussed at the organisation's clinical governance meetings and MAC.

Systems were in place to ensure that complaints and incidents were being managed effectively in accordance with legislation and best practice guidance.

5.2.4 Do recruitment and selection procedures comply with all relevant legislation?

There were recruitment and selection policies and procedures in place that adhered to legislation and best practice guidance.

Mrs Nelson oversees the recruitment and selection of staff for the dental, medical and hair transplant teams and approves all staff appointments. Discussion with Mrs Nelson confirmed that she had a clear understanding of the legislation and best practice guidance.

A review of the staff register evidenced that eight new dental staff and one new medical practitioner had been recruited since the previous inspection. A review of a sample of three personnel files of newly recruited staff evidenced that all relevant recruitment records had been sought; reviewed and stored as required.

There was evidence of job descriptions and formal programmes of induction for the different staff roles. A review of records confirmed that if a professional qualification is a requirement of the post, a registration check is made with the appropriate professional regulatory body.

Discussion with members of the dental team confirmed they have been provided with a job description, contract of employment/agreement and received induction training, commensurate to their role and responsibilities, when they commenced work in the practice.

It was demonstrated that arrangements are in place to ensure the recruitment of staff complies with the legislation and best practice guidance to ensure suitably skilled and qualified staff work in the practice.

5.2.5 How does the establishment ensure that staffing levels are safe to meet the needs of patients?

Staffing arrangements were reviewed and discussed with Mrs Nelson. The staffing structure consists of three teams; the dental team, the medical team and the hair transplant team. Each team has appropriately experienced, skilled and qualified staff involved in the delivery of services.

Staffing provision includes dentists, dental nurses, medical practitioners, registered nurses and a health care assistant, who provide dental care and treatment and day surgery services. It was demonstrated that a robust 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 training matrix was in place to monitor the status of staff training requirements.

Policies and procedures are in place that outline mandatory training to be undertaken, in line with any professional requirements, and the training guidance provided by RQIA.

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

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

Discussion with staff and review of documentation identified that arrangements were in place to check the registration status for all clinical staff on appointment for example: dentists and dental nurses with the General Dental Council (GDC), medical practitioners with the General Medical Council (GMC) and nursing staff with the Nursing and Midwifery Council (NMC).

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

It was evidenced that for dentists and medical practitioners, their professional indemnity continues to be monitored annually.

A record is kept which shows the rota of staff working and the capacity in which they are working.

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

5.2.6 Is the establishment fully equipped and are staff trained to manage medical emergencies?

The arrangements to manage medical emergencies in the establishment were reviewed.

There was a medical emergency policy and procedure in place and a review of this evidenced that it reflected legislation and best practice guidance. Protocols were available to guide all staff on how to manage recognised medical emergencies.

The hospital has two separate emergency kit bags containing all the required emergency medicines and equipment. The emergency kit bags are strategically located to ensure ease of access for the dental, medical and hair transplant teams at any given time.

The British National Formulary (BNF) and the Resuscitation Council (UK) specify the emergency medicines and medical emergency equipment that must be available to safely and effectively manage a medical emergency in a dental practice.

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

Managing medical emergencies is included in the induction programme and refresher training is undertaken annually.

Staff members spoken with 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.

Patient call alert devices are checked daily with a record maintained. These records are included in the ongoing schedule of audit.

A detailed transfer out policy was in place outlining the arrangements for the transfer of an acutely ill patient in the event of a medical emergency or serious post treatment complication, to a Health and Social Care (HSC) hospital**.**

It was determined that good arrangements are in place to ensure the hospital is equipped to manage a medical emergency should this occur.

5.3 How does the hospital ensure that dental services are safe?

5.3.1 Does the dental team provide dental care and treatment using conscious sedation in line with the legislation and guidance?

Conscious sedation helps reduce anxiety, discomfort, and pain during certain procedures. This is accomplished with medications or medical gases to relax the patient.

Mrs Nelson confirmed that conscious sedation is offered if clinically indicated using intravenous (IV) sedation. IV sedation is only offered to patients over the age of 16.

There was a conscious sedation policy and procedure in place that was comprehensive and reflected the legislation and best practice guidance. Review of the environment and equipment evidenced that conscious sedation is being managed in keeping with the Conscious Sedation in Dentistry, Dental Clinic Guidance, (Third Edition); Scottish Dental Clinical Effectiveness Programme (SDCEP).

A review of records and discussion with a dental nurse demonstrated that a full assessment of the patient to confirm the dental treatment required and the need for sedation is undertaken by the dentist providing the sedation.

The dental nurse confirmed that valid written consent is sought for provision of dental care with sedation in accordance with the above best practice guidance.

It was demonstrated that clinical records of patients who had treatment using sedation includes a detailed record of the pre-sedation assessment, the patient's written consent, the patient's visit for sedation including monitoring, the treatment procedure and the recovery of each patient.

Information was available for patients in respect of the treatment provided and aftercare arrangements and a record is maintained to verify that post-treatment instructions were given and explained to the patient and their escort, as appropriate.

The dental team involved in the provision of conscious sedation must receive appropriate practical and clinical training. Mrs Nelson confirmed that all relevant members of the dental team had completed 12 hours of sedation related verifiable continuing professional development (CPD) training in each five year CPD cycle.

A discussion took place regarding the life support training to be undertaken by all clinical team members involved in managing patients having sedation.

Immediate Life Support (ILS) training as laid down by the Resuscitation Council (UK) must be undertaken. A review of the content of the medical emergency refresher training confirmed appropriate staff had undertaken ILS training. Mrs Nelson confirmed that all the main elements of ILS training as outlined in Appendix 2 of Conscious Sedation in Dentistry, Dental Clinic Guidance, (Third Edition); Scottish Dental Clinical Effectiveness Programme (SDCEP) were included.

The medicines used during IV sedation are classified as controlled drugs (CDs). The arrangements for the management of the CDs were reviewed. It was demonstrated that CDs are securely stored at all times and systems were in place for the ordering, administration, reconciliation (stock check) and disposal of these medicines. It was identified that a standard operating procedure (SOP) for CDs was in place and had been signed by all relevant clinical staff.

There are arrangements in place to enable the dental team to safely provide dental care and treatment using conscious sedation, in keeping with legislation and guidance.

5.3.2 Does the dental team adhere to infection prevention and control (IPC) best practice guidance?

The IPC arrangements in relation to the dental service were reviewed throughout to evidence that the risk of infection transmission to patients, visitors and staff was minimised.

The infection prevention and control measures to prevent transmission of respiratory illnesses in the practice was discussed with Mrs Nelson. It was confirmed that arrangements are in place in keeping with the Health and Social Care Public Health Agency guidance Infection Prevention and Control Measures for Respiratory illnesses March 2023 and the Infection Prevention and Control Manual for Northern Ireland. Mrs Nelson confirmed arrangements are in place to check Department of Health (DoH) websites for further advisory information, guidance and alerts in this regard.

There was an overarching IPC policy and associated procedures in place in relation to the dental service. Review of these documents demonstrated that they reflected legislation and best practice guidance. Mrs Nelson confirmed there was a nominated lead dental nurse who had responsibility for IPC and decontamination in the practice. The lead dental nurse had undertaken IPC and decontamination training in line with their continuing professional development and had retained the necessary training certificates as evidence.

During a tour of some areas of the practice, it was observed that clinical and decontamination areas were clean, tidy and uncluttered. All areas of the practice observed were equipped to meet the needs of patients.

The arrangements for personal protective equipment (PPE) were reviewed and it was noted that appropriate PPE was readily available for the dental team in accordance with the treatments provided.

Using the Infection Prevention Society (IPS) audit tool, IPC audits are routinely undertaken by members of the dental team to self-assess compliance with best practice guidance. The purpose of these audits is to assess compliance with key elements of IPC, relevant to dentistry, including the arrangements for environmental cleaning; the use of PPE; hand hygiene practice; and waste and sharps management. This audit also includes the decontamination of reusable dental instruments which is discussed further in the following section of this report. A review of these audits evidenced that they were completed on a six monthly basis and, where applicable, an action plan was generated to address any improvements required.

Hepatitis B vaccination is recommended for clinical members of the dental team as it protects them if exposed to this virus. A system was in place to ensure that relevant members of the dental team have received this vaccination. Discussions with Mrs Nelson confirmed that vaccination history is checked during the recruitment process and vaccination records are retained in personnel files.

Discussion with Mrs Nelson confirmed that members of the dental team had received IPC training relevant to their roles and responsibilities and they demonstrated good knowledge and understanding of these procedures. Review of training records evidenced that the dental team had completed relevant IPC training and had received regular updates.

Review of IPC arrangements evidenced that the dental team adheres to best practice guidance to minimise the risk of infection transmission to patients, visitors and staff.

5.3.3 Does the dental team meet current best practice guidance for the decontamination of reusable dental instruments?

Robust procedures and a dedicated decontamination room must be in place to minimise the risk of infection transmission to patients, visitors and staff in line with Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the DoH.

There was a range of policies and procedures in place for the decontamination of reusable dental instruments that were comprehensive and reflected legislation, minimum standards and best practice guidance.

There was a designated decontamination room separate from patient treatment areas and dedicated to the decontamination process. The design and layout of this room complied with best practice guidance and the equipment was sufficient to meet the requirements of the practice. Records evidencing that the equipment for cleaning and sterilising instruments was inspected, validated, maintained and used in line with the manufacturers' guidance were reviewed. Review of equipment logbooks demonstrated that all required tests to check the efficiency of the machines had been undertaken.

Discussion with a member of the dental team confirmed that they had received training on the decontamination of reusable dental instruments in keeping with their role and responsibilities.

They demonstrated good knowledge and understanding of the decontamination process and were able to describe the equipment treated as single use and the equipment suitable for decontamination.

Decontamination arrangements demonstrated that the dental team are adhering to current best practice guidance on the decontamination of dental instruments.

5.3.4 How does the dental team ensure that appropriate radiographs (x-rays) are taken safely?

The arrangements regarding radiology and radiation safety were reviewed to ensure that appropriate safeguards were in place to protect patients, visitors and staff from the ionising radiation produced by taking an x-ray.

Dental practices are required to notify and register any equipment producing ionising radiation with the Health and Safety Executive Northern Ireland (HSENI). A review of records evidenced the practice had registered with the HSENI.

The practice has six surgeries, five of which have an intra-oral x-ray machine. In addition there is a combined orthopan tomogram/cone beam computed tomography (CBCT/OPG) machine, which is located in a separate room. The equipment inventory reflected all the radiography equipment in place. A review of documentation evidenced that the x-ray equipment had been serviced and maintained in accordance with manufacturer's instructions.

A radiation protection advisor (RPA), medical physics expert (MPE) and radiation protection supervisor (RPS) have been appointed in line with legislation.

Two dedicated radiation protection files containing the relevant local rules, employer's procedures and other additional information were retained. One file included information relating to the intra-oral x-ray machines and the second file included information relating to the CBCT/OPG.

A review of the files confirmed that the Employer had entitled the dental team to undertake specific roles and responsibilities associated with radiology and ensured that these staff had completed appropriate training. The RPS oversees radiation safety within the practice and regularly reviews the radiation protection files to ensure that they are accurate and up to date.

The appointed RPA must undertake a critical examination and acceptance test of all new x-ray equipment; thereafter the RPA must complete a quality assurance test every three years as specified within the legislation.

Mrs Nelson confirmed that no new radiology equipment had been installed since the previous RQIA inspection.

The most recent reports generated by the RPA evidenced that the x-ray equipment had been examined and any recommendations made had been actioned.

A copy of the local rules was on display near each x-ray machine observed and appropriate staff had signed to confirm that they had read and understood these.

Quality assurance systems and processes were in place to ensure that all matters relating to x-rays reflect legislation and best practice guidance. It was evidenced that all measures are taken to optimise radiation dose exposure. This included the use of rectangular collimation, x-ray audits and digital x-ray processing.

The radiology and radiation safety arrangements evidenced that procedures are in place to ensure that appropriate x-rays are taken safely.

5.4 How does the hospital ensure that day surgery services are safe?

5.4.1 Are there safe practices in place for the day surgery services?

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

It was confirmed that prospective patients are invited to attend an initial consultation with the medical practitioner who undertakes the procedure, who will provide an in-depth consultation and assessment and also provide a patient information leaflet specific to the day surgery procedure pertinent to the patient.

The patient is also provided with written information detailing any preparation necessary in advance and also the post procedure aftercare protocol to be followed by the patient.

The medical practitioner performing the surgical procedure is responsible for gaining consent from patients for their care and treatment in line with legislation and guidance. The consent process complies with the GMC's 'Guidance for doctors who offer cosmetic interventions' and the Royal College of Surgeons (RCS) 'Professional Standards for Cosmetic Surgery'.

The scheduling of patients for day surgery procedures is co-ordinated through the hospital's booking system with the involvement of the medical team and the hair transplant clinical team, as relevant. Scheduling takes into account individual patient requirements, staffing levels, the estimated length of the procedure and any associated risks.

The inspection team were informed that patients will have surgical preparation to minimise infection risks. The medical practitioner undertaking the procedure is the nominated person in charge and completes the surgical safety checklist based on World Health Organisation (WHO) guidance. Completion of the surgical checklist and compliance is routinely audited through the hospital's auditing process.

Patients will receive local anaesthesia only. It was confirmed that no other form of sedation would be required. It was confirmed that patients will be observed during and after the procedure by the clinical team.

Patients will be discharged in accordance to discharge criteria by the medical practitioner who undertook the procedure. Patients will be provided with clear post procedure advice, information on follow up and who to contact in the event of a post treatment complication.

A review of the surgical registers evidenced that a surgical register was in place in each clinical treatment room. It was confirmed the hair transplant procedure register was found to contain all of the information required by legislation.

Patient care pathway records were reviewed and found to provide a framework for the clear record of admission, medical history, infection status, medication, observations on admission, the pre-procedure checklist, the WHO surgical safety checklist, intra-procedure details, traceability details, post procedure observations and discharge record.

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

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 the patient's General Practitioner (GP). It was confirmed there is a contract in place with an accredited pathology laboratory service. The pathology services will be subject to internal audit.

It was determined that that appropriate arrangements were in place to ensure patients have a planned programme of care and treatment and have sufficient information to consent to treatment. Safe practices are in place for the provision day surgery services.

5.4.2 How does the service ensure that it adheres to infection prevention and control and decontamination procedures in keeping with best practice guidance for the day surgery services?

The arrangements for IPC procedures concerning all day surgery services were reviewed to evidence that the risk of infection transmission to patients, visitors and staff was minimised.

A range of IPC policies and procedures were in place in regards to IPC for day surgery services.

Observations of the existing treatment room found it to be clean, tidy, uncluttered and finished to a high standard of décor. The treatment room is dedicated for the provision of hair transplant procedures and has a specially designed treatment couch to promote patient comfort during the procedure. An adjacent room is provided for hair transplant patients where they can rest, have a break from the lengthy procedure and avail of light refreshments as desired.

A fridge for the storage of hair follicles is provided in this treatment room should this be required during the hair transplant procedure. A record of daily fridge temperature is maintained to ensure that the fridge temperature remains within the required range of 2 to 8 degrees Celsius.

As previously discussed a variation to registration application was submitted to RQIA by Mrs Nelson on behalf of Marlborough Clinic Belfast Ltd to add a Private Doctor (PD) category of care and also two additional clinical treatment rooms.

The two new treatment rooms were reviewed and were seen to be finished to a high standard and were fully equipped to meet the requirements of treatment rooms for the provision of minor day surgery procedures.

The new treatment rooms had a treatment couch with wipe-able coverings to facilitate effective cleaning. Each room contained hand washing sinks, mounted soap and hand towels dispensers, and hand hygiene posters displayed at each hand hygiene area. Personal protective equipment (PPE) was readily available in keeping with best practice guidance.

Arrangements regarding the decontamination of equipment and reusable medical devices were reviewed. It was confirmed that single use equipment and reusable medical devices are used. Sterile theatre packs are supplied under contract from an accredited central sterile service department (CSSD) based at the Ulster Hospital, Dundonald.

Cleaning records were noted to have been completed and were up to date. Staff described the arrangements to decontaminate the environment and equipment between patients in keeping with best practice.

A review of records confirmed that an IPC audit had been undertaken and all action required had been completed. There is an appointed lead IPC nurse and staff have access to an external IPC nurse consultant. There is access to a microbiologist should advice be required and the Public Health Agency (PHA) details are also available for staff.

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

As previously discussed staff training records confirmed that staff have completed IPC training commensurate with their roles and responsibilities.

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

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

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

5.6 How does a registered provider who is not in day to day management of the practice assure themselves of the quality of the services provided?

Where the business entity operating a dental practice is a corporate body or partnership or an individual owner who is not in day to day management of the practice, 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.

Mrs Nelson was in day to day management of the establishment, therefore the unannounced quality monitoring visits by the registered provider are not applicable.

5.7 Does the dental team have suitable arrangements in place to record equality data?

The arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients was discussed with Mrs Nelson.

6.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Nelson, Responsible Individual, as part of the inspection process and can be found in the main body of the report.

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

Assurance, Challenge and Improvement in Health and Social Care