The Regulation and Quality Improvement Authority

Inspection Report

5 March 2026

Optimax Clinics Limited - Belfast

Type of Service: Independent Hospital-Refractive Eye Lasers
Address: 7 Derryvolgie Avenue, Belfast, BT9 6FL
Telephone number: 028 9066 1118

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 Care Standards for Independent Healthcare Establishments (July 2014)

1.0 Service information

Organisation/Provider: Optimax Clinics Limited **Responsible Individual:** Mr Luis Fernando Gravalos Soria	**Registered Manager**: Mrs Fiona Quinn **Date registered:** 12 August 2019
Person in charge at the time of inspection: Mrs Fiona Quinn	
Categories of care: PT(L) Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers PD Private Doctor	
Brief description of how the service operates: Optimax Clinics Limited - Belfast is registered with the Regulation and Quality Improvement Authority (RQIA) as an Independent Hospital (IH) with the following categories of care: Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers PT(L) and private doctor (PD) categories of care. Optimax Clinics Limited (Optimax) is the registered provider for Optimax Clinics Limited - Belfast and Mr Gravalos Soria is the responsible individual. Optimax Clinics Limited - Belfast provides laser vision correction to persons over 18 years of age. Optimax has nineteen clinics located across the United Kingdom. **Equipment available in the service:** **Laser equipment:** Manufacturer: Schwind Model: Amaris Serial Number: S244 Laser Class: 4 Wavelength: 193 nm Manufacturer: IntraLase Model: FS60 Serial Number: S0506-40039 Laser Class: 3B Wavelength: 1053 nm **Types of laser treatments provided:** Refractive eye surgery – Lasek, Lasik and Photorefractive Keratectomy	

2.0 Inspection summary

This was an announced inspection, undertaken by two care inspectors on 5 March 2026 from 10.00 am to 4.45 pm. 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.

The purpose of the inspection was to assess progress with areas for improvement identified during and since the last inspection and assess compliance with the legislation and minimum standards.

There was evidence of good practice concerning staff recruitment; authorised operator training; safeguarding; laser safety; the management of the patients' care pathway; the management of medical emergencies; infection prevention and control (IPC); the management of clinical records; clinical and organisational governance; and effective communication between patients and staff.

Additional areas of good practice identified included maintaining patient confidentiality, ensuring the core values of privacy and dignity were upheld and providing the relevant information to allow patients to make informed choices.

No immediate concerns were identified regarding the delivery of front line patient 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. This inspection was facilitated by Mrs Quinn, Registered Manager.

The information obtained is then considered before a determination is made on whether the clinic is operating in accordance with the relevant legislation and minimum standards. Examples of good practice are acknowledged and any areas for improvement are discussed with the person in charge and detailed in the quality improvement plan (QIP).

4.0 What people told us about the service

Patients were not present on the day of the inspection and patient feedback was assessed by reviewing the most recent patient satisfaction surveys completed by Optimax Clinics Limited - Belfast.

Posters were issued to Optimax Clinics Limited - Belfast by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire. No patient responses were submitted.

Five 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. All of the staff indicated that they were very satisfied with each of these areas of patient care. No staff responses included comments.

5.0 The inspection

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

The last inspection to Optimax Clinics Limited - Belfast was undertaken on 19 February 2025; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 How does this service ensure that staffing levels are safe to meet the needs of patients and staff are appropriately trained to fulfil the duties of their role?

Staffing arrangements were reviewed and it was confirmed that there are appropriately skilled and qualified staff involved in the delivery of services. The staff team includes a consultant ophthalmologist, an optometrist, registered nurses and laser assistants.

The clinic staff take part in ongoing training to update their knowledge and skills, relevant to their role. Induction programmes relevant to roles and responsibilities are required to be completed when new staff join the team.

A system was in place to monitor all aspects of ongoing professional development.

A review of training files identified that some records were not available in respect of some staff members. This was discussed with Mrs Quinn and following the inspection, evidence was submitted to RQIA, confirming that all authorised operators had now undertaken training in keeping RQIA training guidance.

Discussion with Mrs Quinn and review of documentation identified that arrangements were in place to check the registration status of all clinical staff on appointment and on an ongoing basis; to monitor staff professional indemnity and any practicing privileges agreements.

Staff spoke positively regarding the clinic and their working relationships, they felt valued as members of the team and supported by management.

It was determined that appropriate staffing levels were in place to meet the needs of patients and as a result of the action taken following the inspection, all staff are suitably trained to carry out their duties.

5.2.2 How does the establishment ensure that recruitment and selection procedures are safe?

A recruitment policy and procedure was in place which was comprehensive and reflected best practice guidance.

Optimax has a clinical resources department which oversees the recruitment of medical staff with input from the medical director and Mr Gravalos. A human resources (HR) department oversees the recruitment process for employees and supports Mrs Quinn during the on-boarding process. Discussions confirmed Mrs Quinn had a clear understanding of recruitment and selection legislation and best practice guidance.

The staff register reviewed was found to include the names and details of staff in keeping with legislation. Two new staff members had been appointed since the previous RQIA inspection. A review of both staff members' personnel files evidenced that all recruitment documentation, as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended, had been sought and retained for inspection.

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

5.2.3 How does the service ensure that it is equipped to manage a safeguarding issue should it arise?

Mrs Quinn confirmed that treatments are not provided to persons under the age of 18 years.

Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. The policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The relevant contact details were included for onward referral to the local Health and Social Care Trust should a safeguarding issue arise.

Review of records demonstrated that all staff had received training in safeguarding adults as outlined in the Minimum Care Standards for Independent Healthcare Establishments (July 2014.

Mrs Quinn confirmed that staff were aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified. The safeguarding champion named in the clinic policy had completed safeguarding training at the level required in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016) and minimum standards.

It was confirmed that a copy of the regional guidance document entitled Adult Safeguarding Prevention and Protection in Partnership (July 2015) was available for reference.

Appropriate arrangements were in place to manage a safeguarding issue should it arise.

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

The arrangements in respect of the management of medical emergencies were reviewed.

Review of the medicines management policy found that it accurately reflected the arrangements in place to manage a medical emergency.

Protocols were also available to guide the team on how to manage recognised medical emergencies.

Review of the emergency medicines and equipment found that systems were in place to ensure that the emergency medicines and equipment do not exceed their expiry date and are immediately available. Staff 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 the emergency medicines and equipment.

Discussion with staff confirmed that the management of medical emergencies is included in the induction programme and training is updated on an annual basis in keeping with best practice guidance.

Review of the arrangements to manage a medical emergency identified that staff were suitably trained and appropriate medicines and equipment were in place to manage a medical emergency should one arise.

5.2.5 How does the service ensure that it adheres to infection prevention and control and decontamination procedures?

The arrangements for IPC procedures throughout the clinic were reviewed to evidence that the risk of infection transmission to patients, visitors and staff was minimised.

There were IPC policies and procedures in place that were in keeping with best practice guidance. A tour of the premises was undertaken and the clinic was found to be clean, tidy and uncluttered.

In October 2025, an Optimax regional IPC nurse undertook an audit to ensure compliance with infection prevention and control procedures. The subsequent report was reviewed by both Mrs Quinn and Mr Gravalos and any actions identified had been addressed.

Cleaning schedules were in place and cleaning records were completed and up to date. Mrs Quinn discussed the procedure to decontaminate the environment and equipment between patients and this was in keeping with best practice.

A review of training records confirmed that staff had received IPC training commensurate with their roles and responsibilities.

Staff spoken with on inspection demonstrated good knowledge and understanding of IPC procedures. Personal protective equipment (PPE) was readily available in keeping with best practice guidance and according to the treatments provided.

The laser suite provided dedicated hand washing facilities and hand sanitiser was available throughout the clinic. Mrs Quinn and the IPC lead nurse confirmed only single use equipment is used for refractive laser treatments.

There are contracts in place for disposal of sharps, clinical waste and pharmaceutical waste.

It was evidenced that a robust programme of IPC auditing is in place including an unannounced audit by the IPC expert advisor for Optimax.

Audit compliance rates were found to be high. Mrs Quinn confirmed audit results are shared across all Optimax clinics for learning and development purposes. The findings from incidents relating to IPC matters are also shared and learning is disseminated across all Optimax Clinics. Mrs Quinn told us that regular inter-clinic IPC meetings take place.

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

5.2.6 How does the clinic ensure laser procedures are safe?

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

The service has one laser suite and a number of consultation and treatment rooms. It was confirmed that refractive laser eye procedures are only carried out by a consultant ophthalmologist as the clinical authorised operator, supported by laser assistants acting as non-clinical authorised operators.

An authorised operator register was in place. Advice was provided to Mrs Quinn to establish two authorised operator registers which would distinguish between authorised clinical operators and non-clinical authorised operators. Mrs Quinn was receptive to this advice and following the inspection RQIA received confirmation that this matter had been addressed.

A review of the laser safety files found that they contained the relevant information required with regards to the laser equipment in use. Written confirmation of the appointment and duties of a certified LPA was not available for review. This was discussed with Mrs Quinn and following the inspection, RQIA received evidence that this matter had been addressed. The clinic's LPA had completed a risk assessment of the premises during February 2026.

Mrs Quinn confirmed that laser eye surgical procedures are undertaken by the consultant ophthalmologist in accordance with medical treatment protocols produced by the medical directors of Optimax. Systems were in place to review the medical treatment protocols on an annual basis.

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

- the potential hazards associated with lasers
- controlled and safe access
- authorised operators' responsibilities

- methods of safe working
- safety checks
- personal protective equipment
- prevention of use by unauthorised persons
- adverse incident procedures

Mrs Quinn confirmed that the LPS is aware that when the laser equipment is in use, the safety of all persons in the controlled area is their responsibility.

A review of training records confirmed that all clinical and non-clinical authorised operators had up to date training in Core of Knowledge and had undertaken applications training for the equipment in use.

It was confirmed that the laser surgical register is maintained every time the lasers are operated to include:

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

A review of the laser surgical register identified that it was required to be updated to include all incidents. Advice and guidance was provided to Mrs Quinn in this regard. The laser suite where the laser equipment is used was found to be safe with access controlled to protect other persons while treatment is in progress.

Mrs Quinn confirmed that both sets of doors to the laser suite are locked when the laser equipment is in use and can be opened from the outside in the event of an emergency.

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

Protective eyewear is available for laser assistants when required and for purposes of equipment maintenance.

The laser safety warning signs are displayed and also illuminated outside of the laser suite when the laser is in use and 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 manufacturers' guidance.

Carbon dioxide (CO_2) fire extinguishers suitable for electrical fires were available in the clinic and arrangements were in place to ensure the fire extinguishers are serviced in keeping with manufacturer's instruction.

The fire risk assessment had been reviewed during February 2026.

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

5.2.7 How does the clinic ensure patients have a planned programme of care and have sufficient information to consent to treatment?

Staff confirmed that all patients have a clinical evaluation with an optometrist who provides information and discusses treatment options.

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

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

Patients are provided with written information on the specific procedure to be provided that explains the risks, complications and expected outcomes of the treatment. Patients are also provided with clear post-operative instructions along with contact details if they experience any concerns. Systems were in place to refer patients directly to the consultant ophthalmologist or optometrist if necessary.

Staff informed us that systems were in place to review the patient following surgery at regular intervals if necessary.

Two patient care records reviewed were found to be well documented, contemporaneous and clearly outlined the patient journey.

The management of electronic records within the clinic was found to be in line with legislation and best practice.

It was determined that appropriate arrangements were in place to ensure patients have a planned programme of care and have sufficient information to consent to treatment.

5.2.8 Are robust arrangements in place regarding clinical and organisational

Organisational governance

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

Mr Gravalos is the responsible individual for Optimax Clinics Limited – Belfast.

Mrs Quinn is the registered manager, who is in day to day charge of the clinic, and is supported in this role by the head of commercial operations at Optimax.

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

The most recent unannounced monitoring visit was undertaken during February 2026 by the regional operations manager for Optimax. A report of the visit was produced and made available to Mrs Quinn any other interested parties to read. An action plan had been developed to address any issues identified during the visit which included timescales and the person responsible for completing the action.

Arrangements should be in place to provide copies of these reports to Mr Gravalos as the responsible individual to enable him to monitor progress with the identified actions. It was evidenced that Mr Gravalos had reviewed and signed off the most recent quality monitoring reports.

Optimax Laser Eye Clinic - Belfast has a Medical Advisory Board (MAB) that includes Mr Gravalos along with the chief executive officer, the medical director, senior medical staff and directors of the organisation. A review of minutes confirmed that the MAB meeting had been held quarterly. This meeting is also attended by the operations manager at Optimax who provides Mrs Quinn with an update of any developments at corporate level.

The MAB focuses on issues related to clinical practice such as doctors' performance, clinical outcomes audit, treatment pathways, potential new treatments, medical safety alerts, incidents and regulatory matters. The MAB also reviews doctors practising privileges and any new clinician appointments.

A medical board meeting also takes place each month that reports to the MAB. The medical society is an educational forum, to which clinicians with practicing privileges and other professions are invited. An annual Doctor's meeting is also held.

Mrs Quinn remotely attends a monthly compliance team meeting with fellow clinic managers from across the UK.

Staff spoken to on the day stated that there were good working relationships within the team and that management was responsive to any suggestions or concerns raised by staff. Staff confirmed that they had an effective forum to share their opinions on the service.

Clinical governance

As discussed the clinical team includes a consultant ophthalmologist, an optometrist, a registered nurse and laser technicians/surgical assistants who have evidence of specialist qualifications and skills in refractive laser eye surgery.

The consultant ophthalmologist is considered to be a wholly private doctor as they are not affiliated with the Health and Social Care (HSC) sector in Northern Ireland (NI) and are not on the General Practitioner's (GP's) performer list in NI.

Review of the consultant ophthalmologist'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 GMC
- ongoing annual appraisal by a trained Medical Appraiser
- an appointed responsible officer (RO)
- arrangements for revalidation

As previously discussed the consultant ophthalmologist, who is a clinical authorised operator, has completed training in accordance with RQIA's training and is aware of their responsibilities under GMC Good Medical Practice.

All medical practitioners working within the clinic must have a designated RO. In accordance with the GMC, all doctors must revalidate every five years. The revalidation process requires doctors to collect examples of their work to understand what they are doing well and how they can improve. Experienced senior doctors (called RO's) work with the GMC to make sure doctors are reviewing their work. As part of the revalidation process RO's make a revalidation recommendation to the GMC. Where concerns are raised regarding a doctor's practice information must be shared with their RO who then has a responsibility to share this information with all relevant stakeholders in all areas of the doctor's work.

The consultant ophthalmologist working within the clinic has a designated external RO due to their prescribed connection with other health care organisations.

Practising Privileges

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

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

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

A review of the practising privileges record for the consultant ophthalmologist confirmed that all required documents were in place and had been signed by both parties. The agreement defined the clinician's scope of practice. It was confirmed that the private doctor's practising privileges agreement is reviewed by the MAB and updated every two years.

A review of the oversight arrangements of the granting of practicing privileges agreements has provided assurance of robust medical governance arrangements within the organisation.

Quality assurance

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

The service scheduled regular audits throughout the year and these are undertaken by the Mrs Quinn and staff. The audit programme includes health and safety and general patients' safety-related audits related to the environment, infection control, clinical record keeping and patient feedback amongst others. Results are used to benchmark the clinic against other Optimax services.

Patient satisfaction ratings are reviewed monthly by the clinic, and quarterly and annually by the Optimax compliance team. An annual report is produced for each Optimax clinic. The most recent report indicated that outcomes for patients were consistently positive and met their expectations however, advice and guidance was provided to Mrs Quinn to ensure that this information is also made available to patients and other interested parties. Mrs Quinn was receptive to this advice.

Mrs Quinn discussed how the results of audits are analysed and how identified actions had been used to facilitate quality improvements. A review of a sample of audit action plans demonstrated that actions had been recorded, delegated to relevant staff and progress tracked.

Completed audits and any resulting actions are shared by Mrs Quinn at the Optimax monthly compliance meeting and in turn by the operations director at the senior compliance meeting.

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.

A statement of purpose and patient's guide were in place and Mrs Quinn confirmed that these documents will be kept under review when and updated as necessary.

The RQIA certificate of registration was up to date and displayed appropriately and current insurance policies were in place.

Notifiable Events/Incidents

An incident management policy and procedure was in place. A review of this policy confirmed that it included the reporting arrangements to RQIA and other relevant organisations in accordance with legislation and the RQIA Statutory Notification of Incidents and Deaths.

Discussion with Mrs Quinn and staff confirmed that they recognised incidents and near misses and knew how to report them in line with policy and procedures.

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.

It was confirmed that Mrs Quinn would lead investigation into incidents and near misses and a monthly audit is undertaken. Any learning is shared and discussed with the clinic team locally and managers at the monthly compliance team meetings.

Complaints 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.

Staff told us that a copy of the complaints procedure is made available to patients/and or their representatives on request. Complaint forms are held at reception. Staff spoken to understood the policy on complaints and knew how to acknowledge any verbal or written complaints received.

Optimax has a centralised customer services and complaints handling department where all complaints received are handled and themes are identified. Mrs Quinn confirmed that complaints received since the previous inspection had been investigated and responded to appropriately to include details of all communications with complainants; the result of any investigation; the outcome and any action taken. Mrs Quinn, as the clinic's complaints manager, demonstrated how she records and tracks progress of all complaints locally using a spreadsheet. Mrs Quinn confirmed that complaints are discussed at management meetings and that she shares learning with all staff.

Overall, the governance structures within the clinic provided the required level of assurance to the senior compliance team and the MAB.

5.3 Does the service 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 staff. Discussion and review of information evidenced that the equality data collected was managed in line with best practice.

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 Quinn, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Appendix

Belfast Health and Social Care Trust
caring supporting improving together

Site Details:
Optimax Clinics Ltd
7 Derryvolgie Avenue
BelfastT9 6FL

Laser/IPL Equipment:

Make	Model	Class	Serial Number	Wavelength(s)
Schwind	Amaris	4	S244	193 nm (ArF)
Intralase	FS	3B	0506-40039	1053 nm (Nd:Glass)

Introduction

An inspection of Optimax was performed on 05 March 2026. 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, and appointment of duty holders (LPS/LPA).

Comments & Recommendations:

Overall, the clinic demonstrated good standards of laser safety management. Governance arrangements were clearly established, staff showed an appropriate awareness of laser safety procedures, and documentation was generally well maintained. The systems in place provided effective oversight of laser operations, with only minor areas identified for improvement during the inspection.

1. **Register of Authorised Users**

During review of the Register of Authorised Users, it was noted that all individuals were listed under a single category of Clinical Operator. Several of the listed operators were, in practice, Technical Operators rather than authorised Clinical Operators. This combined approach may lead to ambiguity regarding operator competencies, scope of practice, and responsibilities.

The clinic should maintain two separate registers—one for Authorised Clinical Operators and one for Authorised Technical Operators.

2. **Authorised User Acknowledgement of Clinical Treatment Protocols**

At the time of inspection, there was no documented evidence that the surgeon had formally acknowledged their understanding and acceptance of the clinical treatment protocols. The surgeon should sign to confirm acceptance and understanding of the clinical treatment protocols. This signature should be dated and retained within the Laser Safety File.

3. **LPA Appointment Status**

The clinic's formal appointment of the Laser Protection Adviser (LPA) expired in December 2025.

Although evidence was available demonstrating that the appointed LPA has continued to provide advisory support and undertaken recent work, the absence of a current written appointment leaves the clinic without formal confirmation required by standard 48.6 (Minimum Care Standards). The clinic should update the LPA contract to ensure they have a current written appointment. The new appointment letter should include the duration, remit, and responsibilities, and be placed in the Laser Safety File.

4. **Laser Register and Incident Reporting**

Inspection of the Laser Register identified that one incident had been recorded elsewhere but had not been entered into the laser treatment record within the register. A discrepancy in page numbering was also noted, however, this had been documented and explained within the register. The clinic should ensure that the Laser Register is fully updated to include all incidents, including the one identified during this inspection. A routine review process should be established to verify the completeness and accuracy of all entries. Any errors should be crossed out with a single line to maintain legibility, and all corrections must be initialled and dated by the individual making the amendment. The clinic should inform RQIA when the above points have been addressed

Signed by LPA to RQIA on 27 March 2026

The Regulation and Quality Improvement Authority

RQIA, 1st Floor
James House
Gasworks
2 – 4 Cromac Avenue
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