Inspection Report

12 February 2026

Newry Private Clinic

Type of service: Independent Hospital (IH) – Acute Hospital (Day Surgery), Endoscopy and Private Doctor
Address: Windsor Avenue, Newry, BT34 1EG
Telephone number: 028 3025 7708

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 Healthcare Establishments July 2014

1.0 Service information

Organisation/Registered Provider: Windsor Hill Healthcare Limited **Responsible Individual:** Mr Mark Regan	**Registered Manager:** Mrs Laura McCaul **Date registered:** 25 March 2024
Person in charge at the time of inspection: Mrs Laura McCaul	
Categories of care: Acute Hospital (Day Surgery) - AH(DS) Private Doctor - PD Endoscopy - PT(E)	
Brief description of how the service operates: Newry Private Clinic is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital with acute hospitals (day surgery only) AH (DS); prescribed techniques or prescribed technology: establishments providing endoscopy services PT(E); and private doctor (PD) categories of care. Newry Private Clinic provides a wide range of services and treatments, including outpatient services across a range of medical specialties; diagnostic tests and investigations. There are no overnight beds in this hospital. During 2024 the hospital was extended to provide a purpose built diagnostic radiology suite for MRI, X-ray and Ultrasound and was ready for clinical use by March 2025. The inspection focused solely on those services which fall within regulated activity and the categories of care for which the establishment is registered with RQIA. On 30 September 2025 RQIA were informed that Windsor Hill Healthcare Limited had been acquired by Kingsbridge Healthcare Group Limited. Kingsbridge Healthcare Group Limited is the registered provided for three independent hospitals registered with RQIA. Mr Mark Regan is the responsible individual for Kingsbridge Healthcare Group Limited.	

2.0 Inspection summary

A short notice announced inspection was undertaken to Newry Private Clinic on 12 February 2026 from 10.00 am to 3.30 pm by two care inspectors and on 18 February 2026 from 9.50 am to 12.20 pm by two pharmacy inspectors. Feedback of the inspection findings was delivered to Mrs McCaul, Registered Manager, throughout the inspection process and summarised at the end of both inspection days.

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

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

Two areas for improvement were identified in relation to the recording of the temperature of the medicines refrigerator and storage areas and the disposal of medicines records.

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

The inspection team undertook a tour of the premises and the inspection was facilitated by Mrs McCaul and the clinical manager. Discussions were held with Mr Mark Regan, Responsible Individual and the medical director of Kingsbridge Healthcare Group Limited.

The inspection team also spoke with Mrs McCaul, Registered Manager; the clinical manager and a member of the nursing staff throughout the inspection process.

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

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

4.0 What people told us about the service

Posters were issued to Newry Private Clinic by RQIA prior to the inspection inviting clients and staff to complete an electronic questionnaire.

One patient submitted a response indicating that they felt the care provided was safe and effective, compassionate and that the service was well led. The patient indicated that they were very satisfied with each of these areas of care and provided an additional comment complimenting the friendly welcome and professional approach shown by all staff they encountered.

No staff responses were received.

Through discussion with a number of staff who had differing roles and responsibilities it was determined that staffing levels and morale were good with evidence of good multidisciplinary team working and effective communication between staff.

5.0 The inspection

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

Areas for improvement from the last inspection on 12 December 2024		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 19 (2) Schedule 2, as amended	The responsible persons shall ensure that an AccessNI enhanced disclosure check is completed and the outcome recorded for any relevant person who is to commence employment at Newry Private Clinic.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.2.	

Area for improvement 2 **Ref:** Regulation 19 (2) (d) as amended	The responsible persons shall ensure that all required recruitment records are in place prior to the commencement of employment for any staff; or any private doctor or consultant medical practitioner providing services under practising privileges.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.2.	
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 6.7	The responsible persons shall ensure all treatment and care is recorded in the patient clinical record.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.3.	

5.2 Inspection findings

5.2.1 Organisation and clinical governance

Organisational Governance

As previously stated, Newry Private Clinic is now part of Kingsbridge Healthcare Group Limited (KHG). Ms Laura McCaul, Registered Manager, is the nominated individual with overall responsibility for the day to day operational management of Newry Private Clinic.

Mr Mark Regan, KHG, submitted a responsible individual application to RQIA in respect of Newry Private Clinic. Following due process this application has been approved by RQIA.

Mr Regan was available for discussion on 12 February 2026 and outlined the arrangements that have been implemented by KHG to ensure the smooth transition of Newry Private Clinic into the KHG organisational governance framework.

Where the business entity operating a registered service is a corporate body or partnership or an individual owner who is not in day to day management of the establishment, unannounced quality monitoring visits by the registered provider must be undertaken and documented every six months; as required by Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005. Mr Regan confirmed that six monthly unannounced quality monitoring visits will be undertaken on behalf of the KHG.

The inspection team recognised that Newry Private Clinic was going through a period of change transitioning into the KHG corporate governance systems and processes as outlined in the KHG's 'Governance and Compliance Strategy and Framework'.

A review of the updated KHG organisational structure charts demonstrated that Newry Private Clinic and staff are included within KHG structures.

During this inspection discussions with Mr Regan; the medical director, KHG; Mrs McCaul and other staff members, confirmed that the integration of Newry Private Clinic into KHG is progressing well. An effective organisation and governance transitioning process was described to RQIA that demonstrated clear lines of accountability to support the delivery of quality services and maintain high standards of care during this process.

Ms McCaul informed us that she has attended a range of senior management team (SMT) meetings and been warmly welcomed at these meetings. A range of quality and governance meetings at KHG Board and at local hospital level take place. These meetings are attended by representatives from the SMT, clinical leads, and general managers with a view to ensuring the efficient and effective flow of information throughout the organisation. Each group has a set agenda reflective of its specific remit. Quality and governance groups include:

- Monthly meeting of the Local Governance and Quality Team (LGQT) and the Intensive care unit (ICU) Governance and Quality Team
- Quarterly meeting of the KHG Administrative and Quality Team (GAQT); inclusive of estates, finance, procurement, human resources, operations and contracts
- Quarterly meeting of the KHG Medical Advisory Committee (MAC) meeting
- Weekly meeting of the local hospital management team (LMT)

Separate quality and governance teams are in place for compliance and risk, information technology (IT), infection prevention and control (IPC) and estates.

A range of minutes from governance and quality meetings were made available for review. A review minutes of meetings demonstrated that information is disseminated to staff via general managers, department team leads either face to face or by emails.

The Competition and Markets Authority (CMA) requires that all hospitals and consultants offering private treatment submit data to the Private Healthcare Information Network (PHIN) as the Information Organisation for private healthcare. This provides people considering private healthcare with clear information to help them make an informed choice of which consultant and hospital is right for them. We were informed that an electronic system for receiving patient experience feedback has been implemented which enables the KHG to feed into PHIN. However, it was confirmed Newry Private Clinic does not provide any private treatment of procedures that requires submission to PHIN.

Policies and procedures were available for staff reference and discussion with Mrs McCaul and the clinical manager confirmed that a structure is in place to ensure that KHG policies and procedures were being systematically introduced to all Newry Private Clinic staff. Staff reported they were aware of the policies and how to access them.

Staff who spoke with us were able to describe their roles and responsibilities and confirmed that there were good working relationships within Newry Private Clinic and with their new KHG colleagues, who were responsive to any suggestions or concerns raised.

The RQIA certificate of registration was up to date and displayed appropriately.

Clinical and medical governance

A small team of consultants with specialist qualifications work at Newry Private Clinic.

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

The medical director provides medical leadership and has overall responsibility for the delivery of the clinical governance framework.

As previously outlined the MAC operates at group level and meets quarterly with responsibility for surgeon performance and surgery specific matters. Terms of reference for the MAC were in place and these have been developed in accordance with Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments (2014). It was evidenced that the MAC meetings have standing agenda items and are used as a forum to discuss clinical governance issues; the appointment and renewal of practising privileges agreements; the review of performance indicators; corrective action in relation to adverse clinical incidents; and any other untoward event or near miss. A review of MAC meeting minutes confirmed that these meetings were being undertaken on a quarterly basis in line with the criteria set out in Standard 30.

In accordance with the requirements of registration with the GMC, all doctors must revalidate every five years. The revalidation process requires doctors to collect examples of their work to understand what they are doing well and how they can improve.

Experienced senior doctors work as Responsible Officers (ROs) with the GMC to 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 KHG is registered with the GMC as a designated body and have an appointed RO.

A number of consultants are considered to be wholly private doctors as they are GMC registered doctors who do not have a prescribed connection to a RO within the Health and Social Care (HSC) sector in Northern Ireland.

A review of a sample of three private consultants' details confirmed evidence of the following:

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

- an appointed RO
- arrangements for revalidation

Appraisal is a key part of revalidation and includes the appraisee providing evidence of their individual continuing professional development (CPD) activities undertaken in accordance with the GMC Good Medical Practice.

KHG has implemented an online portal to enable consultants to submit their annual appraisal documentation. This provides an accurate and up to date position on each consultant's appraisal status which clearly evidences any delay. This provides the medical director and the MAC with oversight of the status of all individual consultant's medical appraisals.

The arrangements for oversight and recording of mandatory training and professional development activities in accordance with best practice guidance was discussed with the medical director and Mrs McCaul. All consultants, working under practicing privileges, are required to provide evidence of mandatory training.

Discussion with Mrs McCaul and review of records demonstrated that training compliance rates are subject to ongoing audit and monitoring at monthly and quarterly intervals and are also included in the quarterly LGQT and MAC meetings. Review of the most recent report detailing compliance rates for medical staff training confirmed that a high percentage of medical staff have completed or have scheduled dates to undertake mandatory training.

In KHG clinical audit is managed by individual departments and clinical specialities. KHG has a rolling programme of key clinical audits and individual audits are also undertaken by clinical staff. Consultants are encouraged to complete one clinical audit per year.

A mechanism is in place for reporting and recording of all clinical incidents; for regular review all such incidents; consideration of issues of concern or complaint relating to the clinical practice of an individual where identified; and to bring to the attention of the medical director and the MAC for review and consideration.

It was confirmed that audit findings, including IPC audit findings, are shared at local and group quality governance meetings and at the IPC steering group meetings.

Practising Privileges

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

Practicing 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 procedure for the granting, review and withdrawal of practicing privileges agreements was not available for review as this document was undergoing revision and is awaiting ratification by the MAC.

The medical director confirmed that all medical practitioners working in Newry Private Clinic now had a KHG practising privileges agreement in place. A review of a sample of records evidenced

that there was a practising privileges agreement between each private doctor and KHG, which set out terms and conditions.

Review of minutes demonstrated that practicing privileges matters, including the restriction/suspension of privileges, are discussed and reviewed during MAC meetings.

The MAC has agreed the timeframe during which annual appraisals should be submitted, and discussion with the medical director confirmed the actions to be taken if annual appraisals are not submitted by the deadline. It was confirmed that KHG require the completion of specific areas of mandatory training, in addition to having professional indemnity and Information Commissioner's Office (ICO) registration in place to enable approval of a practising privileges application.

As mentioned previously, an online platform has been implemented which also facilitates consultants to electronically submit all required documentation required for a practising privileges application and renewal. This electronic system has a tracking capability to issue reminders and other communication to consultants in addition to providing oversight to senior management.

The medical director stated that the platform has facilitated clinician engagement and improved the process for reviewing and granting practicing privileges, reviewing the scope of practice and monitoring compliance.

Good oversight arrangements of the granting of practicing privileges agreements were in place and provided assurance of robust medical governance arrangements within the organisation.

Quality assurance

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

Significant incidents and themes reported are discussed during the LMT, LGCT and MAC meetings.

There was a robust programme for internal audit to monitor compliance with policies and processes. Audits are completed monthly, quarterly and annually as per the KHG's audit schedule. If required, an action plan is developed to address any shortfalls identified during the audit process.

It was demonstrated that a system was also in place to ensure that urgent communications, safety alerts and notices are reviewed and, where appropriate, made available to key staff in a timely manner.

Notifiable Events/Incidents

The Governance and Compliance Strategy and Framework provides an overview of the mechanisms in place, and of roles and responsibilities at all levels throughout KHG, to oversee, report and respond to clinical risks, incidents and near misses. This includes reporting requirements to external bodies as required and the arrangements for the management of national safety alerts. The Adverse Incident Policy further describes the internal electronic

reporting mechanism, which is accessible to all staff, and corresponding investigation pathways following categorisation of the incident.

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

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

As previously mentioned significant incidents and themes reported are discussed at the organisation's clinical governance meetings, the MAC and health and safety committees.

Complaints Management

A copy of the complaints policy was available for review and was seen to be in line with current Department of Health (DoH) guidance on complaints handling. The policy was found to have been updated in line with the Health and Social Care Model Complaints Handling Procedures' (MCHP) published for Health and Social Care Trusts within Northern Ireland by the Northern Ireland Public Services Ombudsman (NIPSO) on 1 July 2025 and introduced by all Health Care Trusts on 1 January 2026.

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

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

Discussion with Mr Regan, the medical director and Mrs McCaul described an effective governance structure that provides a process and system of accountability to support the delivery of good quality service and to monitor and maintain high standards of care.

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

The staffing arrangements in respect of Newry Private Clinic were reviewed.

A staff register was available to review and was found to be up to date and largely contained staff details in keeping with legislation. It was advised to include a date of leaving column within the staff register and management gave assurances on this matter.

A review of duty rotas and discussion with staff evidenced that there were sufficient staff in various roles to fulfil the needs of the hospital and patients.

A recruitment policy and procedure was in place.

Discussion with Mrs McCaul confirmed that staff members had been recruited since the previous inspection. A sample of four personnel files of newly recruited staff were reviewed. It

was identified that not all information as listed in Regulation 19, Schedule 2 of the Independent Health Care Regulations (NI) 2005, in respect of these staff was available for review. This was discussed with Mrs McCaul and the clinical services manager and it was confirmed that the missing information was attributed to the transitioning of recruitment services to the KHG. Following the inspection evidence of action taken on this matter was submitted to RQIA.

Enhanced AccessNI disclosure checks had been completed prior to commencement of employment in respect of the new staff members. It was determined that area for improvement 1 made against the regulations as outlined in section 5.1, has been addressed.

Mrs McCaul was aware that all recruitment documentation as outlined in Regulation 19, Schedule 2 of the Independent Health Care Regulations (NI) 2005 should be sought and retained for any new staff member recruited in future. It was determined that area for improvement 2 made against the regulations as outlined in section 5.1, has been addressed.

A structured induction and orientation programme, relevant to roles and responsibilities, was available for newly recruited staff. Records of completed inductions had been retained in the personnel files reviewed. It was evidenced that a process is in place to ensure appraisals are completed on an annual basis and staff reported that they were well supported and that there were good working relationships throughout the hospital.

All staff working in Newry Private Clinic, whether employed directly or under practicing privileges agreements, must complete training in keeping with RQIA training guidance and their professional regulatory body.

Training matrices were in place to record the status of staff training and it was noted that this included medical staff who work under practicing privileges agreements. The respective training matrices are overseen by Mrs McCaul and the clinical manager.

Robust arrangements were in place to check the registration status for all clinical staff on an ongoing basis. The arrangement for monitoring the professional indemnity of relevant staff was also in place.

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

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

The arrangements for the provision of day surgery and endoscopy services in the hospital were outlined under the establishment's statement of purpose and categories of care. A review of these arrangements evidenced that the service operates in accordance with best practice and national standards to ensure care delivery is safe and effective.

It was confirmed that no cystoscopy procedures had been carried out in Newry Private Clinic since March 2025 following the departure of the clinician carrying out the cystoscopies. Management confirmed that it is hoped a replacement clinician will be in place in the near future. A limited range of minor dermatology surgical procedures were being undertaken as day surgery procedures.

The scheduling of patients for day surgery or endoscopy procedures is co-ordinated by hospital management with the involvement of the consultant and senior nursing staff. Scheduling takes into account individual patient requirements, staffing levels, the nature of the procedure and any associated risks. The patient is provided with information about the procedure and any preparation necessary in advance, together with the consent form.

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

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

It was confirmed that patients are observed during and after the procedure by appropriately trained staff. Patients are discharged in accordance to discharge criteria by the nursing staff. This was fully reflected in the standard operating procedure (SOP) and the patient care pathway record.

It was confirmed that if there were any concerns about the patient's condition, the consultant would be immediately informed for ongoing management. Patients are provided with clear, post procedure advice information on follow up and who to contact in the event of a post treatment emergency.

A surgical/endoscopy register is maintained for most procedures undertaken in treatment room five (designated for minor surgical and endoscopy procedures). It was advised to ensure all procedures carried out in treatment room five are included in the register.

It was noted that additional administration related equipment had been located in treatment room five since the last RQIA inspection. Management confirmed that with limited use of the room for minor surgical procedures and the temporary cessation of cystoscopy service this treatment room had been used as a consultation room. Management were advised to seek advice from their appointed IPC advisor regarding the proposed dual function of treatment room five to ensure the clinical integrity of the room is not compromised by this proposal. There should be clear standard operating protocols in place that ensure the clinical integrity of the treatment room at all times.

Two completed endoscopy patient care pathway records were reviewed. They were found to be well completed and included details of the record of admission, medical history, IPC status, medication, observations on admission, pre-procedure checklist, surgical safety checklist (WHO) and intra- procedure details. It was advised to further expand the surgical safety checklist and following the inspection evidence was submitted to RQIA confirming that this matter had been addressed. It was determined that area for improvement 1 made against the standards as outlined in section 5.1, has been addressed.

There were procedures for the management of specimens relating to the collection, labelling, storage, preservation, transport and administration of specimens. A specimen log is maintained.

It was confirmed that endoscopy and surgical equipment are all single use.

It was determined that the minor surgical day services are provided in a safe and effective manner.

5.2.4 Medicines Management

Medication management was reviewed during the inspection to determine if medicines were managed safely and effectively.

Written policies and standard operating procedures for the management of medicines were available for staff reference. There was evidence these were routinely reviewed and updated. Systems were in place to ensure that any updates were communicated to the nursing and medical staff. The staff spoken with demonstrated a detailed knowledge of medicines management policies and procedures. As detailed below the medicines management policy and procedure should be updated to include the arrangements for the disposal of medicines.

Details of currently prescribed medicines and allergy status were obtained as part of the initial consultation by the doctor. An electronic record system was used to record information pertaining to each individual episode of care for each patient. Records of medicines administered during clinics were well maintained. Records of prescriptions generated were recorded as well as advice and information on medicines provided.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Medicines were ordered by designated staff. Medicines are supplied by the Kingsbridge pharmacy, who provided regular advice and support to the hospital.

Only medicines used in the clinics, for example, eye drops, local anaesthetics and hormonal intrauterine devices, were held in the hospital. They were stored safely and securely and in accordance with the manufacturer's instructions. Where prescriptions of medicines were required, a private prescription, signed by the doctor was issued to the patient.

Medicines were stored safely and securely in locked cabinets within the clinic rooms. Medicines were also stored in the treatment room which provided a medicines storage cabinet, emergency boxes and a medicines refrigerator. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The contents of emergency boxes were checked at regular intervals. Controlled drugs were not held in the hospital.

The temperature of medicines storage areas were not monitored and recorded each day; this is necessary to ensure medicines are stored according to the manufacturers' instructions. Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. Only the current temperature of the medicine refrigerator was monitored each day; this does not provide evidence that the temperature is maintained within the required range at all times. An area for improvement has been made in this regard.

The registered manager advised that medicines were disposed of either by disposal into the sharps bins for collection by a waste management company or by return to the Kingsbridge

pharmacy. Records of disposal were not maintained. The records required were discussed with the registered manager who agreed to implement a record of disposal following the inspection. The medicines policy required updating with details of the returns procedure and record keeping. An area for improvement has been made in this regard.
It was evidenced that qualified staff undertook the management of medicines. Systems were in place to ensure training on medicines management was provided for nurses and doctors as part of their induction; and refresher training was provided in accordance with the hospital's mandatory training programme. The registered manager and healthcare staff spoken with advised that staff received an induction pack tailored to their specific area of work and that the completion of training was monitored.

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

There were incident reporting systems in place for identifying, recording, reporting, analysing and learning from adverse incidents and near misses involving medicines and medicinal products. Incidents were discussed at the monthly Drug and Therapeutics meetings and quarterly MAC meetings and any learning from incidents was discussed with staff.

Arrangements were in place to audit the management of medicines. Evidence of this activity was maintained. This included a monthly medicines management audit, a review of patient records at the end of each clinic and stock level and date checking for the medicines held in theatre.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with Minimum Care Standards for Independent Healthcare Establishments (July 2014)

	Regulations	Standards
Total number of Areas for Improvement	0	2

Areas for improvement and details of the QIP were discussed with Mrs McCaul, Registered Manager and the clinical manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with the minimum standards for Independent Healthcare Establishments (July 2014)

Area for improvement 1 **Ref:** Standard 26 **Stated:** First time **To be completed by:** 18 February 2026	The responsible individual shall ensure that the temperature of the medicine refrigerator and storage areas are monitored daily to ensure that medicines are stored at the manufacturers' recommended temperature. Ref: 5.2.4
	Response by registered person detailing the actions taken: Following review of the current process, a revised and more detailed temperature monitoring template has been introduced for both the medicine refrigerator and ambient clinical storage areas. The updated documentation includes recording of minimum, maximum and actual temperatures, together with confirmation that the thermometer has been reset daily following checks. Daily monitoring is now being completed and signed by the responsible staff member in line with manufacturer recommendations and Standard 26 requirements. Guidance regarding actions required should temperatures fall outside the permitted range has also been incorporated into the monitoring documentation. Completed temperature monitoring records are maintained and are available for inspection upon request.
Area for improvement 2 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 18 February 2026	The responsible individual shall review and update the medicines policy with respect to disposal of medicines to ensure that records of disposal are maintained. Ref: 5.2.4
	Response by registered person detailing the actions taken: The Medicines Policy has been reviewed and updated to strengthen the process relating to the disposal and destruction of medicines. A dedicated Medicines Destruction Book has now been introduced within the clinic to ensure all medicines requiring destruction are appropriately recorded and traceable. A medicines destruction return sheet is now completed at the time of disposal, documenting details including the medicine, quantity, reason for destruction, date, and signatures of staff involved in the process. The updated process ensures that accurate and auditable records of medicines disposal are maintained in line with Standard 28 requirements. Completed records are securely retained and are available for inspection upon request.

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

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