

Inspection Report

29 June 2026



Solasta Healthcare Limited

Type of service: Independent Hospital (IH) – Day Surgery Services /
Laser Eye Surgery Services

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Assurance, Challenge and Improvement in Health and Social Care

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/> [The Independent Health Care Regulations \(Northern Ireland\) 2005](#) and [Minimum Care Standards for Independent Healthcare Establishments \(July 2014\)](#)

1.0 Service information

Registered provider: Solasta Healthcare Limited	Registered manager: Ms Ruth Collins
Responsible individual: Ms Ruth Collins	Date registered: 4 November 2024
Person in charge at the time of inspection: Ms Ruth Collins	
Categories of care: AH (DS) Acute hospitals (day surgery only) Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers PT(L)	
Brief description of how the service operates: Solasta Healthcare Limited is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital (IH) with an acute hospitals (day surgery only) AH (DS) category of care. Solasta Healthcare Limited provides eye surgery services for patients aged 18 year and over on a day case basis. A variation to registration application was submitted to RQIA to add the following category of care: PT (L) – Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers. This is discussed further in section 2.0 of this report.	
Equipment available in the service: Laser Suite Manufacturer: Nidek Model: YC200S-PLUS Serial Number: Y2S51031 Laser Class: 3B Wavelength: 532nm / 1064nm	
Types of treatment provided: YAG laser Capsulotomy YAG Iridotomy YAG Viteolysis YAG Anterior Stomal Puncture SLT (Selective Laser Trabeculectomy)	

2.0 Inspection summary

An announced inspection was undertaken to Solasta Healthcare Limited on 29 June 2026 from 10.00 am to 6.00 pm by three care inspectors. RQIA's laser protection advisor (LPA) accompanied the inspectors and reviewed the laser equipment and the laser safety arrangements. Their findings and recommendations are appended to this report.

Feedback of the onsite inspection findings was delivered to Ms Ruth Collins, Responsible Individual and Registered Manager, and members of the Solasta Healthcare staff team on the day of the inspection.

This inspection focused on four main themes; organisational and clinical governance; the safe practice for provision of day eye surgery services; laser safety and staffing arrangements.

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

There was evidence of good practice in relation to the organisational and clinical governance arrangements; recruitment and selection of staff; staff training; laser safety; patient safety in respect of the management of the patients' care pathway 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.

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 was facilitated by Ms Collins.

During the inspection we spoke with Ms Collins, Responsible Individual; the medical director; the clinical nurse lead and a theatre practitioner.

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 Solasta Healthcare Limited by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire.

No patient responses were submitted.

Six staff submitted responses indicating that they felt the care provided was safe and effective and compassionate. All three respondents indicated that they were very satisfied with each of these areas of care. Regarding the service being well led, six respondents indicated they were satisfied or very satisfied in this regard. Four respondents provided positive comments regarding team work, leadership, communication and a patient focused approach.

Three visiting professionals submitted responses indicating they felt the care provided was safe and effective, compassionate and that the service was well led. All respondents indicated that they were very satisfied with each of these areas of care. Two respondents provided positive comments regarding safe care, the professionalism of the staff team and leadership arrangements.

Through discussion with a number of staff who have differing roles and responsibilities it was determined that staffing levels and morale was 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?

The last inspection to Solasta Healthcare Limited was undertaken on 15 August 2025; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Are robust arrangement in place regarding clinical and organisational governance?

Organisational Governance

Various aspects of the organisational systems were discussed with Ms Collins and the medical director. A range of minutes were reviewed which identified that regular Medical Advisory Committee (MAC) and director meetings take place and evidenced that information is disseminated to staff via Ms Collins either face to face or by emails.

Agenda items include clinical governance, quality, risk, compliance and audit. Meeting minutes detail the outcomes with time limited actions and the identified persons to address each action point and provide assurance to the responsible individual and the board of directors. In addition, corporate finance meetings, operational team meetings, theatre day huddles and group supervision meetings are held and are attended by Ms Collins and corresponding representative from clinical and operational staff teams.

Documents viewed during the inspection described a wide range of governance related activities, which included, monitoring of customer satisfaction, the outcomes of key performance indicators (KPI), audits and incident management and trend analysis. Audits were used to assess performance against agreed standards as part of a rolling audit programme.

Audits included hand hygiene, environmental, infection prevention and control, theatre management, medical emergency arrangements, complaints and incidents. Mechanisms were in place to ensure results from the audits were reviewed during the MAC and director meetings and are shared with all staff.

Where the business entity operating a registered establishment 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. As Ms Collins is day to day management, unannounced monitoring visits are not required.

Policies and procedures were available for staff reference and discussion with Ms Collins confirmed that a structure is in place to ensure that policies are being reviewed in a systematic manner. Staff reported they were aware of the policies and how to access them.

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

A procedure for the dissemination and implementation of regional and national guidance, urgent communications, safety alerts and notices was in place to ensure all patient safety communications received were distributed and actioned appropriately in a timely manner.

The communication of information is also provided at staff meetings and by email.

It was also demonstrated that there were robust governance systems in place regarding the monitoring of medical, nursing and other health care professional bodies' registration status.

Staff who spoke with us were able to describe their roles and responsibilities and confirmed that there were good working relationships with managers, who were responsive to any suggestions or concerns raised.

Examination of insurance documentation confirmed that insurance policies were in place.

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

Clinical and medical governance

Clinical governance within Solasta Healthcare Limited was overseen by the MAC and director meetings. 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, the outcome of completed audits, staff training compliance figures, the review of complaints/compliments and also estate management matters. These meetings were being undertaken on a quarterly basis in line with the criteria set out in Standard 30.

A team of consultant surgeons who have specialist qualifications and skills work in Solasta Healthcare Limited.

Solasta Healthcare Limited monitors individual consultant files, professional indemnity and appraisals. Registration status is verified with the General Medical Council (GMC).

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. As part of the revalidation process, responsible officers (RO) make revalidation recommendations 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 the areas of the doctor's work. It was established that all doctors working in the hospital have a designated RO. Solasta Healthcare Limited has established links with ROs of the doctors working in the organisation and should a concern arise. A discussion was held around how concerns would be raised regarding a doctor's practice with the MAC and within the wider Health and Social Care (HSC) sector.

It was confirmed that no wholly private doctors work in Solasta Healthcare Limited. A private doctor is a medical practitioner who is not affiliated with the HSC sector in Northern Ireland (NI) and is not on the General Practitioner's (GPs) performer list in NI.

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 (2024) guidance. A review of records demonstrated that the hospital retains a copy of each consultant's annual appraisal document.

Whilst it is the responsibility of GMC registrants to keep up to date with their CPD activities, the CPD learning activities may not meet with legislative mandatory training such as fire safety, safeguarding adults, children and young people, infection prevention and control and resuscitation. Discussion with Ms Collins and a review of records demonstrated that a staff training matrix was in place that included all staff and provided up to date information on staff training compliance. A review of the matrix evidenced a high rate of compliance in all areas of training and where training was due for renewal or had expired, these were highlighted for follow up. As previously discussed, training compliance rates are included in the quarterly MAC meetings.

Discussion with Ms Collins confirmed that a record of induction and individual training records and certificates were retained to verify that training had been successfully completed.

Practising Privileges

The only mechanism for a medical practitioner to work in a registered independent hospital is either under a practising privileges agreement or through direct employment by the hospital. Ms Collins confirmed that all medical practitioners working in Solasta Healthcare Limited have a practising privileges agreement in place.

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

It was demonstrated that practising privileges can only be granted 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. It was noted that the practicing privileges application process required a minor amendment regarding Regulation 19. This matter was discussed with Ms Collins and following the inspection, RQIA received evidence that this matter had been addressed. It was noted that the practising privileges application also includes a requirement to demonstrate completion of specific areas of mandatory training.

Discussion with Ms Collins and the medical director confirmed the arrangements regarding the granting of practicing privileges. It was confirmed that a written practicing privileges agreement was in place between each medical practitioner and Solasta Healthcare Limited, setting out the terms and conditions which had been signed by both parties. Ms Collins advised that, prior to granting practicing privileges, a face to face meeting takes place between the medical practitioner, the medical director and herself. Ms Collins was advised to maintain a record of the date of these meetings. Ms Collins was receptive to this advice and addressed this matter during the inspection.

As previously discussed, practising privileges matters are discussed and reviewed during the MAC meetings.

Discussion with Ms Collins and the medical director 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 care and treatment delivered to patients at appropriate intervals. These arrangements include seeking client feedback on the quality of services provided. Ms Collins was advised to collate the most recent client feedback survey findings into an anonymised report and, if relevant, to develop an action plan to address relevant findings. Ms Collins was receptive to this advice and following the inspection RQIA received evidence that this matter had been addressed. It was found that the survey returned positive feedback.

Significant incidents and themes reported are discussed at the MAC and director 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 Solasta Healthcare Limited audit schedule. The results are monitored by department leads and Ms Collins. Where required, an action plan is developed to address any shortfalls identified during the audit process. Actions identified for improvement are embedded into practice.

A range of policies and procedures were available outlining the arrangements associated with the treatments provided. Policies and procedures associated with laser treatments are currently in development.

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

Notifiable Events/Incidents

A policy 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.

Ms Collins confirmed that any learning from incidents would be discussed with staff. A process was in place to analyse incidents and events to identify actual or potential trends, or weakness in specific areas, so 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 MAC and director meetings.

Complaints Management

A copy of the complaints procedure was available in the hospital and was found to be in line with the relevant legislation and Department of Health (DoH) guidance on complaints handling.

Ms Collins confirmed that a copy of the complaints procedure is made available for patients/and or their representatives on request and staff demonstrated a good awareness of complaints management.

It was confirmed that any complaints that had been received since the previous inspection had been investigated and responded to appropriately. This includes details of all communications with the complainant; the result of any investigation; the outcome and any action taken. It was confirmed that any learning coming out of a complaint is disseminated across all staff groups to drive improvement in the quality of this service, which staff confirmed during the inspection.

The management of complaints is reviewed on a weekly basis, where complaints are ongoing, a quarterly audit of complaints is undertaken to identify trends or themes emerging at an early stage. A review of the audit of complaints is included as standing agenda item for the MAC meetings.

Risk Management

Systems were in place to support good risk management within the hospital. This ensures that the likelihood of adverse incidents, risks and complaints are minimised by effective identification, prioritisation, treatment and management.

Risks were documented, collated and tracked through the use of a risk register which provided assurance about the effective identification and management of risk.

Overall, the governance structures within the hospital provided the required level of assurance to the responsible individual and the board of directors.

5.2.2 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 clients, visitors and staff was minimised. There were IPC policies and procedures in place that were in keeping with best practice guidance.

It was evidenced that a robust programme of IPC auditing is in place.

A tour of the premises was undertaken and the clinic was found to be clean, tidy and uncluttered. Staff described the arrangements to decontaminate the environment and equipment between clients in keeping with best practice.

A review of training records confirmed that staff had received IPC training commensurate with their roles and responsibilities. Staff demonstrated good knowledge and understanding of IPC procedures.

Theatre staff informed us that reusable medical devices are used during some surgical procedures. It was confirmed that arrangements were in place to ensure the decontamination of equipment and reusable medical devices is in line with manufacturer's instructions and current best practice. A contract was in place with the central sterile services department (CSSD) of a health and social care trust for this purpose.

Waste management arrangements were in place and clinical waste bins were pedal operated in keeping with best practice guidance.

The laser suite and treatment room provided dedicated hand washing facilities and hand sanitiser was available throughout the clinic.

Ms Collins confirmed arrangements are in place to access the Department of Health (DoH) and Public Health Agency (PHA) websites with regards to advisory information, guidance and alerts in relation to IPC.

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

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

We reviewed the arrangements for the provision of day surgery in the hospital 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.

The scheduling of patients for day surgery procedures including laser eye surgery will be co-ordinated by the patient co-ordinator with the involvement of the consultant ophthalmologist and senior nursing staff. Scheduling takes into account individual patient requirements, staffing levels, the nature of the procedure and any associated risks.

The patient meets with the consultant ophthalmologist for assessment and to commence the consent process in advance of the day of surgery. The patient receives information about the procedure and any preparation necessary in advance, together with the consent form.

On the day of the surgery patients are admitted to an admissions room. The consent process is completed by the consultant carrying out the procedure as part of the admission process. Patients will receive local anaesthesia which is provided by a consultant anaesthetist. It was confirmed that intravenous or general anaesthesia is not provided on this site. Pre-operative eye drops are instilled in the recovery area and the patient is then escorted to the theatre.

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

It was confirmed that patients will be observed during and after the procedure by appropriately trained staff.

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

A surgical register is well maintained for all procedures undertaken in the hospital. It was confirmed that no surgical assistants were used in the hospital.

Three electronic patient Day Surgery Patient Care Pathways were reviewed and found to provide a clear record of admission, medical history, IPC status, medication, observations on admission, pre-procedure checklist, surgical safety checklist (WHO), intra-procedure details, traceability details and post procedure observations. Advice was provided on some minor amendments to the patient record to ensure complete clarity on the patient journey. Ms Collins and her team were receptive to this advice. It was confirmed a periodic patient record audit is carried out.

Supplies of sterile instrument packs are obtained from an approved sterile services department under contract from a health and social care trust. There were robust measures in place to monitor the traceability of all surgical instruments used in the clinic. Clinical equipment was evidenced to be clean and fit for purpose, and traceability labels were used to identify when equipment had been cleaned.

A wide range of comprehensive policies and procedures were in place to ensure that safe and effective care is provided to patients, which are in accordance with good practice guidelines and national standards. However, the policies and procedures largely referred to the provision of cataract surgery. It was advised to ensure the policies and procedures reflect the range of surgical services to be provided including laser eye surgery. The management team provided assurances on this matter. It was confirmed there are no pathology services required for the day surgery service.

An emergency trolley is located in the theatre area and checked daily by nursing staff. The emergency trolley is sealed with a tag, each day the trolley is opened and the entire contents are checked against the checklist, upon completion the check list is signed and dated by the person undertaking the check, a new tag is applied and the number of the tag is entered on the checklist. Advice was provided on recording further detail on the monitoring records for the emergency equipment and medicines; and providing a dose chart, needles and syringes with the adrenaline box. Management provided assurances on this matter.

On a daily basis the equipment on the top of the trolley is checked, this includes the automated external defibrillator, the oxygen cylinder and the suction machine, upon completion the checklist is signed by the person completing the check. It was also confirmed that the emergency checklists are audited to ensure compliance with this process.

It was determined that appropriate arrangements were in place for the day surgery service.

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

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

A review of the laser safety file found that with the exception of the medical treatment protocols, it contained relevant information in relation to the laser equipment in place. Ms Collins was receptive to advice provided in this regard.

There were arrangements in place confirming the appointment of certified LPA which is reviewed on an annual basis.

It was confirmed that laser eye procedures are only carried out by consultant ophthalmologists acting as the clinical authorised operators for the laser. A register of clinical authorised operators for the laser is maintained and kept up to date.

The clinic's LPA completed a risk assessment of the premises and the laser safety arrangements.

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.

Advice and guidance was provided to Ms Collins to review the referral pathway for suspected eye injury as outlined in the local rules to ensure it is reflective of local arrangements. Ms Collins provided assurance that this matter would be addressed following the inspection.

It was confirmed that laser eye procedures are undertaken in accordance with medical treatment protocols produced by the medical director of Solasta Healthcare Limited in consultation with the consultant ophthalmologists. Ms Collins was advised to further develop the medical treatment protocols to include a procedure to be followed in event of equipment failure, and a process by which clinical authorised operators could sign to confirm they have reviewed, understood and will comply with the treatment protocol. Ms Collins provided assurance that these matters would be addressed following the inspection.

During the inspection it was confirmed that medical treatment protocols will be reviewed on a two yearly basis. Ms Collins provided assurance that a document control system will be implemented to ensure all medical treatment protocols are subject to regular review and that review dates and authorisation will be recorded. During the inspection the medical director updated the treatment protocol for YAG Anterior Stromal Puncture to include an approval and issue date.

Due to a recent functional change to the Northern Ireland Adverse Incident Centre (NIAIC), any incidents relation to medical devices should be forwarded directly to the Medicines and Healthcare products Regulatory Agency (MHRA) using their yellow card reporting scheme. Ms Collins agreed to have corresponding laser safety documentation, policies and procedures updated to reflect this change.

It was demonstrated that staff are aware that when the laser equipment is in use, the safety of all persons in the controlled area is the responsibility of the laser protection supervisor (LPS). Arrangements were in place for a person who is suitably skilled to deputise for the LPS in their absence.

As previously discussed a review of training records confirmed that all clinical authorised operators had up to date training in core of knowledge; basic life support; infection prevention and control; fire safety awareness; and safeguarding adults at risk of harm in keeping with the RQIA training guidance. Ms Collins confirmed that the equipment supplier had provided application training to the clinical authorised operators on the use of the Nidek YC200S-PLUS. Ms Collins was advised to seek formal confirmation of this training from the equipment supplier. Following the inspection RQIA received evidence that this matter had been addressed.

It was evidenced that a laser register is in place for the laser equipment which includes:

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

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

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

Protective eyewear was available. A review of the eyewear evidenced that it was provided as outlined by the LPA in the local rules.

The laser safety warning sign is illuminated outside of the laser treatment room when the laser equipment is in use and turned off when not in use, as described within the local rules.

Arrangements have been established for equipment to be serviced and maintained in line with the manufacturers' guidance. The installation report for the laser equipment was reviewed.

Carbon dioxide (CO₂) 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.

As a result of the assurances given and action taken following the inspection it was determined that appropriate arrangements were in place to operate the laser equipment.

5.2.5 How does the service ensure that patients have a planned programme of care and have sufficient information to consent to treatment?

It was confirmed that all patients have an initial discussion with a patient co-ordinator followed by an initial consultation with an ophthalmologist who discusses the cost of treatment and treatment options respectively.

During the initial consultation, patients are asked to complete a health questionnaire. Systems were in place to contact the patient's general practitioner (GP), with their consent, for further information if necessary. Ms Collins was receptive to advice and guidance to develop a GP letter to include the patient's laser treatment and corresponding laser treatment wavelength(s).

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

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. Ms Collins was advised to further develop patient information to include information on their laser treatment and corresponding laser treatment wavelength(s) in the event of attending an emergency department. Ms Collins provided assurance this matter would be addressed following the inspection.

Systems were in place to review the patient following surgery and emergency on-call arrangements in place to refer patients directly to the consultant ophthalmologist if necessary.

As a result of the assurances given, 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.

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

A recruitment policy and procedure was in place that was in keeping with legislation and best practice guidance. Ms Collins is aware that should staff be recruited in the future all recruitment documentation as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended, must be sought and retained for inspection.

A staff register was available to review and contained staff details in keeping with legislation. Ms Collins was advised to further develop the staff register to include all medical staff. Mrs Collins provided assurance that this matter would be addressed following the inspection.

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

Discussion with Ms Collins confirmed that supervision has been completed on a regular basis and appraisals had been completed on an annual basis. Staff reported that they were well supported and fully involved in discussions about their personal and professional development.

As previously discussed a training matrix is maintained with in date training and a rolling programme of updates evidenced. Induction programme templates were in place relevant to specific roles within the hospital.

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

It was demonstrated that there was a robust system in place to review the registration details of all health and social care professionals with their professional bodies. Records were available for review in this regard.

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.

5.2.7 Is the statement of purpose in keeping with Regulation 7, Schedule 1 of The Independent Health Care Regulations (Northern Ireland) 2005?

A statement of purpose was prepared in a recognised format which covered the key areas and themes outlined in Regulation 7, Schedule 1 of The Independent Health Care Regulations (Northern Ireland) 2005. Ms Collins is aware that the statement of purpose is considered to be a live document and should be reviewed and updated as and when necessary

5.2.8 Is the patient guide in keeping with Regulation 8 of The Independent Health Care Regulations (Northern Ireland) 2005?

A patient guide was prepared in a recognised format. Review of the patient guide identified that a minor amendment was required to reflect the key areas and themes outlined in Regulation 8 of The Independent Health Care Regulations (Northern Ireland) 2005. Following the inspection RQIA received evidence that this matter had been addressed. Ms Collins is aware that the patient guide is considered to be a live document and should be reviewed and updated as and when necessary.

6. Quality Improvement Plan/Areas for Improvement

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

Appendix 1

23 July 2026

Laser Protection Report**Site Details:**

Solasta Healthcare
 Unit 70
 The Boulevard
 Cascum Rd
 Banbridge
 BT32 4LF

Laser Protection Adviser appointed by site: Anna Bass, Lasernet Ltd

Laser/IPL Equipment:

Make	Model	Class	Serial Number	Wavelength(s)
Nidek	YC200S-PLUS	3B	Y2S51031	532 nm / 1064 nm

Introduction

An inspection of Solasta Healthcare was performed on 29 June 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, appointment of duty holders (LPS/LPA)

Comments & Recommendations:

Overall, the clinic demonstrated good standards of laser safety management. Governance arrangements were clearly established, and documentation was generally well maintained, with only minor areas identified for improvement during the inspection.

1. Laser Treatment Protocols:

- a) The treatment protocols were not included within the Laser Safety File and were only available within the Treatment Room File. Whilst Authorised Users had signed to confirm that they had read and understood the relevant policies and protocols in the Laser Safety File, there was no documented evidence to demonstrate that they had also reviewed and understood the relevant treatment protocols.

The clinic should implement a system to ensure that all Authorised Users have read and acknowledged the relevant treatment protocols, with records retained to demonstrate compliance.

- b) None of the treatment protocols reviewed included a documented procedure to be followed in the event of equipment failure. This is a requirement of Standard 48.3 of the Minimum Care Standards.

Treatment protocols should be reviewed and updated to ensure compliance with the requirements of this standard.

- c) There was no formal documented process for the review and updating of treatment protocols. In addition, the treatment protocol for YAG Anterior Stromal Puncture did not have an approval or issue date. During discussions, the clinic advised that protocols would be reviewed every two years, however, this requirement had not been formally documented.

A document control system should be implemented to ensure treatment protocols are subject to regular review, approval, and version control, with review dates and authorisation clearly recorded.

- 2. Local Rules:** Section 10.5, relating to suspected eye injury, directs staff to refer affected persons to the Ophthalmology Department at CAH.

This section of the local rules should be reviewed to ensure that the referral pathway remains current and appropriate.

- 3. Training Records:** The clinic advised that applications training was delivered by the equipment supplier, however there was no formal record of the training available for inspection.

The clinic should obtain and retain certificates or written confirmation from the training provider to demonstrate that all relevant staff have successfully completed applications training.

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



Mrs Jane Brown
Laser Protection Adviser to RQIA



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