The Regulation and Quality Improvement Authority

Inspection Report

5 August 2026



Face Therapy NI Ltd

Type of service: Independent Hospital (IH) – Surgical Services
Address: 545 Antrim Road, Belfast, BT15 3BU
Telephone number: 078 1064 8887

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/Registered Provider: Face Therapy NI Ltd **Responsible Individual:** Ms Lisa Waring	**Registered Manager:** Ms Lisa Waring **Date registered:** 30 November 2023
Person in charge at the time of inspection: Ms Lisa Waring	
Categories of care: Acute Hospital (Day Surgery) AH(DS) Private Doctor PD Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers PT(L) Prescribed techniques or prescribed technology: establishments using intense light sources PT(IL)	
Brief description of how the service operates: Face Therapy NI Ltd is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital with acute hospitals (day surgery only) AH (DS); private doctor (PD); prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers PT(L); and prescribed techniques or prescribed technology: establishments using intense light sources PT(IL) categories of care. Face Therapy NI Ltd provides a wide range of services and treatments, including minor surgical day case procedures, private doctor cosmetic/aesthetic treatments and cosmetic laser procedures. There are no overnight beds provided in this hospital. Face Therapy NI Ltd also provides a range of other cosmetic/aesthetic treatments and a training academy. This inspection focused solely on those treatments that fall within regulated activity and the categories of care for which the establishment is registered with RQIA. **Laser multi-platform equipment:** Manufacturer: Sciton Model: mJOULE Serial Number: 51722 Laser Class: 4 Wavelengths: 1927nm (laser) and 300-1400nm (Broadband Light- BBL) Hand pieces: MOXI laser and BBL Hero The mJOULE is a multi-platform machine that is capable of operating as a MOXI laser and as BBL by changing the hand piece.	

Types of laser treatments provided:
Skin rejuvenation

Types of IPL (BBL) treatments provided:
Skin rejuvenation
Acne scarring reduction

2.0 Inspection summary

A short notice announced inspection was undertaken to Face Therapy NI Ltd by two care inspectors on 5 August 2026 from 10.00 am to 6.30 pm.

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

Two areas for improvement have been identified against the regulations regarding the statement of purpose and staff register. Three areas for improvement have been identified against the standards in relation to laser safety.

Examples of good practice were evidenced and no concerns were identified in relation to 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.

Prior to the inspection we reviewed a range of information relevant to the hospital. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the hospital
- written and verbal communication received since the previous care inspection
- the previous care inspection report and quality improvement plan (QIP).

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

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

4.0 What people told us about the service

Posters were issued to Face Therapy NI Ltd by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire.

Twelve patients submitted responses. Patient responses indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led. All patients indicated that they were very satisfied with each of these areas of their care. Ten responses included positive comments in regards to the environment and the friendliness and professionalism of the staff.

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 staff indicated that they were very satisfied with each of these areas of care. Three staff responses included positive comments in regards to the supportive working environment.

Two relatives/visitors and three visiting professionals submitted questionnaire responses. Respondents indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. All respondents indicated that they were very satisfied with each of these areas of care. Four respondents included positive comments in regards to the professionalism of staff and the environment.

Through discussion with a number of staff who have 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 action has been taken to meet any areas for improvement identified at or since last inspection?

The most recent inspection of Face Therapy NI Ltd was a variation to registration inspection undertaken on 4 June 2025. This inspection reviewed the readiness of the establishment to offer minor day surgical procedures and no areas for improvement had been identified.

The last inspection to review laser safety in Face Therapy NI Ltd was undertaken on 16 September 2024 and one area for improvement was identified at this time.

Quality Improvement Plan		
Action required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments (July 2014)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 48.21	The responsible individual shall ensure that the Laser Protection Supervisor (LPS) regularly reviews the laser safety file, to ensure that it is accurate, up to date and contains all of the relevant information in relation to laser and intense light equipment.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.4.	

5.2 Inspection findings

5.2.1 Governance and Leadership

Organisational Governance

Ms Waring is the responsible individual and registered manager of Face Therapy NI Ltd. Ms Waring is a registered nurse and authorised operator of the laser equipment and has responsibility for the day to day management of Face Therapy NI Ltd. Ms Waring is supported by a newly recruited medical director who specialises in aesthetics and works in the establishment throughout the week.

Ms Waring confirmed that a consultant plastic surgeon who works in England and an obstetrics and gynaecology consultant who works in the Belfast Health and Social Care Trust also work as medical practitioners in Face Therapy NI Ltd. Other staff who work in the establishment include a registered nurse, a clinic co-ordinator, skin therapists/authorised operators and front of house 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 Waring is responsible for the day to day management of the hospital, the unannounced quality monitoring visits by the registered provider are not applicable.

Staff who spoke with us confirmed that there were good working relationships and that Ms Waring was responsive to any suggestions or concerns raised.

Various aspects of the organisational systems were discussed with Ms Waring and the medical director. We were advised that quarterly Medical Advisory Committee (MAC) meetings take place and are attended by Ms Waring, the medical director, the medical consultants and two independent advisors. Minutes of MAC meetings were retained and available for inspection. It was confirmed that the MAC terms of reference includes information in accordance with the minimum standards. Discussion with staff confirmed that that information is disseminated to staff following these meetings. In addition, staff meetings are also held monthly and the minutes of these meetings were retained and available for inspection.

A range of audits were available to review and if required, an action plan is developed to address any shortfalls identified during the audit process. Audits available for review included infection prevention and control (IPC), health and safety, the environment, equipment, waste management and clinical records keeping.

Policies and procedures were available for staff reference. Staff were aware of the policies and procedures in place and how to access them. Ms Waring confirmed that a system is in place to ensure that policies are being reviewed in a systematic manner.

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 provides clear information to those considering private healthcare to help them to make an informed choice of which consultant and hospital is right for them. This was discussed and Ms Waring was advised to submit data to PHIN regarding the services offered and consultants providing private healthcare in Face Therapy NI Ltd.

A review of the statement of purpose identified that the laser and IPL treatments were not included in the list of procedures offered and the statement of purpose did not fully reflect all of the staff who work in the hospital in the organisational chart included. An area for improvement against the regulations has been made in this regard.

Ms Waring was advised to ensure the statement of purpose and patient guide are reviewed and updated as and when necessary.

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

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

Clinical governance

As discussed, the medical director is supported by two medical consultants who have specialist qualifications and skills in surgical services. During the inspection, it was confirmed that the medical director and one of the consultants were considered to be wholly private doctors (PDs); being General Medical Council (GMC) registered doctors who do not have a prescribed connection to a responsible officer (RO) within the Health and Social Care (HSC) sector in Northern Ireland.

A review of both of the PDs details confirmed there was evidence of the following:

- confirmation of identity
- current GMC registration
- professional indemnity insurance
- qualifications in line with service provided
- each doctor/surgeon has an appointed RO
- ongoing professional development and continued medical education that meets the requirements of the Royal Colleges and the GMC

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. There was evidence of ongoing annual appraisal by a trained medical appraiser in respect of one of the private doctors. It was identified that the other private doctor did not have evidence of a recent appraisal however, assurances were given that the appraisal was being undertaken and evidence of this was provided during the inspection.

All medical practitioners working within the establishment 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 ROs, 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 current arrangements supporting medical appraisal and revalidation with a RO for all consultants working in the establishment was discussed. A review of the medical governance arrangements evidenced that the hospital maintains established links with the wider HSC Trusts. Ms Waring should have a robust system in place for exchanging information with other relevant HSC or independent sector organisations when there are concerns or potential concerns regarding an individual clinician's practice. No concerns were noted at this time.

It was confirmed that the MAC has responsibility for the consultants' surgical performance and surgery specific matters. The individual consultant files are monitored, checking registration with the GMC, professional indemnity and appraisals on an ongoing basis.

It was confirmed that the PDs are aware of their responsibilities under GMC Good Medical Practice.

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, IPC and resuscitation. A system had thus been implemented to provide assurances to Ms Waring that all staff have completed training in keeping with the RQIA training guidance, CPD and in accordance with their role within the hospital.

Practising Privileges

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

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

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

A selection of practising privileges agreements were reviewed and found to be in accordance with best practice. It was confirmed that practising privileges agreements are reviewed at least every two years.

It was confirmed that the MAC has oversight of the granting of practicing privileges agreements and there is evidence 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.

It was confirmed that Face Therapy NI Ltd have a programme for internal audit to monitor compliance with policies and processes. If required, an action plan is developed to address any shortfalls identified during the audit process.

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 incidents and near misses was in place.

Ms Waring and staff confirmed that any learning from incidents would be discussed with staff. Any incidents and events would be analysed to detect actual or potential 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 incidents would be reported and discussed at the quarterly MAC 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.

Discussion with staff 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.

Ms Waring confirmed that no complaints had been received since the previous inspection. A review of the complaints documentation and discussion with staff demonstrated that complaints would be investigated and responded to appropriately. This would include details of all

communications with complainants; the result of any investigation; the outcome and any action taken. It was confirmed that any learning would be disseminated across all staff groups to drive improvement in the quality of this service, which staff confirmed during the inspection.

It was confirmed that if any complaints were received, they would be reported and discussed at the quarterly 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.

It was determined that the overall governance structure within the hospital provides the required level of assurance to the MAC and senior management.

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

The arrangements for the recruitment and selection of staff were reviewed. A review of the recruitment policy identified that it required further development. The revised recruitment policy was submitted to RQIA following the inspection and was found to be in keeping with legislation and best practice guidance.

The staff register was reviewed and advice provided to Ms Waring that it should include all staff information as specified in the regulations. A revised staff register was submitted to RQIA following the inspection and was found to require further development to comply with legislation. An area for improvement against the regulations has been made in the regard.

Ms Waring confirmed that some staff members had been recruited since the previous inspection. A review of a sample of newly recruited staff members' personnel files identified that all information as listed in Regulation 19, Schedule 2 of The Independent Health Care Regulations (NI) 2005 had been sought and retained.

Evidence was in place to confirm that enhanced AccessNI disclosure checks had been undertaken for newly recruited staff. It was found however, that original AccessNI disclosure certificates were retained in a number of the personnel files reviewed. Advice and guidance was given to Ms Waring to ensure that the storage of AccessNI certificates is reviewed in keeping with the AccessNI code of practice. Ms Waring agreed to address this matter 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 hospital and patients.

A review of a selection of training records evidenced that staff had completed mandatory training in keeping with the RQIA training guidance.

Ms Waring confirmed that job descriptions have been issued to new staff on commencement of employment.

It was confirmed that staff inductions had been undertaken for newly recruited staff however, some of the induction records reviewed had not been signed and dated by both parties. This was discussed and Ms Waring was advised to ensure that induction records are signed and dated as required.

A system was 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 suitably skilled and qualified staff work in the hospital in accordance with legislation. Addressing the area for improvement will ensure that staff records are maintained in accordance with legislation.

5.2.3 Are there safe practices in place for the surgical service?

The arrangements in place to support the provision of safe and effective surgical practices were reviewed.

Following the previous variation to registration inspection to add the AH(DS) category of care, a condition was placed on the registration of Face Therapy NI Ltd, dated 18 July 2025, as follows:

Ms Waring agrees that no new day surgical procedures will be introduced without the prior written approval of RQIA.

Following this condition being applied, RQIA received correspondence from Ms Waring to inform RQIA that they would be introducing additional minor surgical procedures and written approval was given. However, on the day of the inspection, it was noted that one of the additional minor surgical procedures had been carried out prior to written approval from RQIA. Ms Waring has been advised to ensure that the list of surgical procedures undertaken in Face Therapy NI Ltd is kept up to date and that no new surgical procedures are introduced until after written approval has been sought from RQIA.

We reviewed the arrangements for the provision of day surgery in the hospital outlined under the statement of purpose. It was confirmed that the hospital provides day surgical services under local anaesthesia only, as appropriate. No procedures are undertaken using intravenous sedation or using a general anaesthetic.

A wide range of comprehensive policies and procedures were in place in regards to surgical services. The policies reviewed had been signed off by appropriately trained and experienced medical staff.

The two treatment rooms used for surgical procedures in Face Therapy NI Ltd were clean and clutter free. Discussion with staff confirmed that IPC training had been undertaken, cleaning schedules were in place and appropriate procedures were also in place for the decontamination of reusable equipment between use. Hand washing facilities were available and adequate supplies of personal protective equipment (PPE) were provided. Ms Waring was reminded that liquid hand soap should be appropriately labelled in accordance with the control of substances hazard to health regulations and this was addressed during the inspection.

During the previous inspection Ms Waring was advised to source an IPC external advisor to carry out a comprehensive IPC audit. Ms Waring confirmed that an IPC audit had been conducted and a report had been issued. A review of records evidenced that internal IPC audits had also been conducted and any issues identified had been addressed.

The scheduling of patients for surgical procedures is co-ordinated by the nursing staff and the consultants. Staff confirmed that on any given day, only one patient is scheduled to have surgery in the morning and one patient in the afternoon. Scheduling takes into account individual patient requirements, staffing levels, the nature of the procedure and any associated risks.

The patient has a full consultation with the performing consultant surgeon, prior to the day of admission and is sent information about the procedure to be undertaken 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.

It was confirmed that nursing staff and the consultant are present during the procedure, all with identified roles. 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 checklist and compliance is routinely audited through the hospital's auditing process. Advice was provided to ensure the checklist includes the name of the person completing it and the date completed.

Staff confirmed that single use surgical instruments are used and that the reprocessing of surgical instruments would not be undertaken. Sterile surgical packs are supplied by an external source which is an accredited central sterile service department (CSSD). Staff confirmed that there are measures in place to monitor the traceability of all surgical instruments used in the hospital. Clinical equipment was evidenced to be clean and fit for purpose.

A review of the surgical register maintained for all surgical procedures undertaken in the hospital was found to contain most of the information required by legislation. Ms Waring was advised to ensure that the pages of this register are numbered and the register includes the name and signature of the nurse in attendance for all procedures undertaken in line with legislation. This was discussed and Ms Waring gave assurances on this matter.

It was confirmed that patients are observed during and after the surgical procedure by the nurse in charge. Patients are discharged in accordance with 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 are provided with clear post-operative advice, information on follow up and who to contact in the event of a post treatment emergency. Ms Waring was advised to ensure that the recording of the patient's discharge is further developed to include more detail and she gave assurances that this issue would be addressed.

Patient care pathway records were reviewed and found to provide a framework for the clear record of admission, medical history, IPC status, medication, observations on admission, pre-procedure checklist, WHO surgical safety checklist, intra-procedure details, post procedure observations and discharge record. It was noted that the venous thromboembolism (VTE) assessment did not include the name of the person completing the assessment and the date the assessment was completed. This was discussed and Ms Waring gave assurances that this issue would be addressed.

A policy was in place to guide staff on the management of medical emergencies to include the on call arrangements for medical staff and the transfer of patients to nearby hospitals. An emergency trolley was located outside the treatment rooms and checked daily by staff. The monitoring checklist included a suction machine however, this piece of equipment had not been provided. Ms Waring and staff were reminded to ensure that the list of medical emergency equipment only includes the equipment provided. Ms Waring gave assurances that this issue would be addressed.

A massive blood loss policy and procedure was in place. Staff confirmed that emergency transfer arrangements were in place and the patient's consultant would arrange the transfer out by liaising with nearby hospital services.

Following the inspection RQIA received evidence that some of the staff have undertaken aseptic non-touch technique training (ANTT) during August 2026. Ms Waring was reminded to ensure that all relevant staff undertake ANTT training in keeping with best practice.

Ms Waring confirmed that patients presenting with suspicious lesions would not be treated and instead referred to a specialist dermatologist for further investigation with the patients consent. It was confirmed that tissue samples/biopsies are not undertaken in Face Therapy NI Ltd and as a result a pathology laboratory service is not required.

As a result of assurances given, it was determined that safe practices are in place for the delivery of minor day surgery services.

5.2.4 How does the service ensure that laser and IPL procedures are safe and clients have sufficient information to consent to treatment?

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

A laser safety file was in place which contained all the relevant up to date information in relation to laser and IPL equipment. It is determined that area for improvement 1, made against the standards as outlined in section 5.1, has been met.

There was written confirmation of the appointment and duties of a certified laser protection advisor (LPA) which is reviewed on an annual basis.

Up to date local rules were in place which have been developed by the LPA. The local rules contained the relevant information about the laser and IPL equipment being used. It was identified that the local rules did not contain a review date and had not been signed by authorised operators to state that they had read and understood. Following the inspection, RQIA received evidence that these issues had been addressed.

The establishment's LPA completed a risk assessment of the premises during January 2026 and all recommendations made by the LPA have been addressed. The renewal date for the risk assessment was confirmed following the inspection.

The medical treatment protocols had been produced by a named registered medical practitioner. It was demonstrated that the protocols contained the relevant information about the treatments being provided and are due to expire during September 2026. It was established that systems are in place to review the medical treatment protocols when due.

Discussion with a staff member identified that patch tests were not being undertaken in keeping with the time frames identified in corresponding treatment protocols. This was discussed and an area for improvement against the standards has been made in this regard.

As previously discussed, the local rules had been signed by authorised operators to state that they had read and understood these however, the authorised operators had not signed to state that they had read and understood the medical treatment protocols. This was discussed and an area for improvement against the standards has been made in this regard.

Staff told us that laser and IPL treatments are not provided to persons under the age of 18 years.

Ms Waring is aware that the laser protection supervisor (LPS) has overall responsibility for safety during laser and IPL treatments and a list of authorised operators is maintained.

The environment in which the laser and IPL equipment is used was found to be safe and controlled to protect other persons while treatment is in progress. The controlled area is clearly defined and not used for other purposes, or as access to areas, when treatment is being carried out.

The door to the treatment room is locked when the laser and IPL equipment is in use but can be opened from the outside in the event of an emergency. Authorised operators were aware that the laser safety warning sign should only be displayed when the laser and IPL equipment is in use and removed when not in use.

The laser and IPL equipment is operated using a keypad code. Arrangements are in place for the safe custody of the keypad code when not in use. Protective eyewear is available for the client and operator as outlined in the local rules.

Face Therapy NI Ltd did not have a laser register in place. Ms Waring was advised to develop, implement and maintain a laser register. Authorised operators must complete the relevant section of the register every time the equipment is operated. The laser register should include:

- the name of the person treated
- the date
- the operator
- the treatment given
- the precise exposure
- any accident or adverse incident

An area for improvement against the standards has been made in this regard.

There are arrangements in place to service and maintain the laser and IPL equipment in line with the manufacturer's guidance. The most recent service report of the laser and IPL equipment was reviewed.

There is written information for clients that provides a clear explanation of any treatment and includes pre and post treatment information.

Each client's personal information is recorded including their general practitioner (GP) details in keeping with legislative requirements and clients are asked to complete a health questionnaire. Two client care records were reviewed. There was an accurate and up to date treatment record for both clients which included:

- client details
- medical history
- signed consent form
- skin assessment (where appropriate)
- patch test (where appropriate)
- record of treatment delivered including number of shots and fluence settings (where appropriate)

Face Therapy NI Ltd takes photographs as evidence of treatment outcomes with the client's consent. A sample of electronic consent forms were reviewed and in the main, these were completed accurately with the exception of one. Advice and guidance was given in this regard and Ms Waring was receptive to this.

Observations made evidenced that client records are securely stored.

Addressing the areas for improvement will ensure that appropriate arrangements are in place to operate the laser and IPL equipment.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and Minimum Care Standards for Independent Healthcare Establishments (July 2014).

	Regulations	Standards
Total number of Areas for Improvement	2	3

The areas for improvement and details of the QIP were discussed with Ms Waring as part of the inspection process. The timescale for completion commences from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 7 (1) **Stated:** First time **To be completed by:** 5 August 2026	The responsible individual shall ensure that the statement of purpose is revised to include all information in accordance with legislation. Ref: 5.2.1
	Response by registered person detailing the actions taken: Lisa Waring confirms that the Statement of Purpose has been revised to include laser and IPL treatments, and the organisational chart has been updated to reflect all staff working in the hospital.

Area for improvement 2 **Ref:** Regulation 21 (3) (a) **Stated:** First time **To be completed by:** 5 August 2026	The responsible individual shall ensure that the staff register is kept up to date and includes all relevant information as specified within Schedule 3 Part II of the Independent Health Care Regulations (Northern Ireland) 2005. Ref: 5.2.2
	Response by registered person detailing the actions taken: Lisa Waring confirms that the staff register has been updated to include all information required by Schedule 3 Part II of the Independent Health Care Regulations (Northern Ireland) 2005 and is kept up to date.
Action required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments (July 2014)	
Area for improvement 1 **Ref:** Standard 48.3 **Stated:** First time **To be completed by:** 5 August 2026	The responsible individual shall ensure that laser and IPL procedures are carried out by authorised operators in accordance with the medical treatment protocols. Ref: 5.2.4
	Response by registered person detailing the actions taken: Lisa Waring confirms that all authorised operators have reviewed the medical treatment protocols and now carry out laser and IPL procedures in accordance with them, including the specified patch test timeframes.
Area for improvement 2 **Ref:** Standard 48.6 **Stated:** First time **To be completed by:** 5 August 2026	The responsible individual shall ensure that all authorised operators have signed to indicate that they accept and understand the medical treatment protocols drawn up for the use of the laser and IPL equipment. Ref: 5.2.4
	Response by registered person detailing the actions taken: Lisa Waring confirms that all authorised operators have signed the medical treatment protocols for laser and IPL equipment to confirm that they accept and understand them.

Area for improvement 3 **Ref:** Standard 48.9 **Stated:** First time **To be completed by:** 5 August 2026	The responsible individual shall ensure that a laser register is developed and completed on every occasion the laser is operated. The following information must be recorded in the laser register: • the name of the person treated • the date • the operator • the treatment given • the precise exposure • any accident or adverse incident Ref: 5.2.4
	Response by registered person detailing the actions taken: Lisa Waring confirms that a laser register has been implemented and is completed on every occasion the laser or IPL equipment is operated. It records the name of the person treated, date, operator, treatment given, precise exposure, and any accident or adverse incident.

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





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