The Regulation and Quality Improvement Authority

Inspection Report

30 & 31 July 2026



Kingsbridge Diagnostic and Treatment Centre

Type of service: Independent Hospital (IH) – Day Surgery Services, Endoscopy Services (day cases only), Private Doctor, Laser Eye Surgery Services

Address: Dataworks Kings Hall Health & Well Being Hub,
Upper Lisburn Road, Belfast, BT9 6GW
Telephone number: 028 9066 7878

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

Organisation/Registered Provider: Kingsbridge Healthcare Group Limited **Responsible Individual:** Mr Mark Regan	**Registered Manager:** Mrs Ashling Green **Date registered:** 11 April 2024
Person in charge at the time of inspection: Mrs Ashling Green	
Categories of care: AH(DS) - Acute Hospital (Day Surgery) PD - Private Doctor PT(E) - Endoscopy PT(L) - Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers	
Brief description of how the service operates: Kingsbridge Diagnostic and Treatment Centre (KDTC) 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); private doctor (PD) and laser services PT(L) categories of care. KDTC provides a wide range of outpatient services and treatment that do not require general anaesthesia; this covers a range of medical specialties, diagnostic tests and investigations including endoscopy services, surgical day case procedures, lens surgery and laser eye procedures. Kingsbridge Healthcare Group Limited is the registered provider for four independent hospitals registered with RQIA. Mr Mark Regan is the responsible individual for Kingsbridge Healthcare Group Limited. **Laser equipment available in the service:** Manufacturer: Lumenis Model: Aura Yag PT Serial Number: YA44-0165 Laser Class: 3B Wavelength: 1064nm	

Manufacturer: Zeiss
Model: Visumax 800
Serial Number: 9511100388
Laser Class: 3B
Wavelength: 1043nm

Manufacturer: Zeiss
Model: Mel 90
Serial Number: 9507700033
Laser Class: 4
Wavelength: 193nm

Types of laser treatment provided:

- LASIK (laser assisted in-situ keratomileusis)
- SMILE (small incision lenticule extraction)
- PRK (photorefractive keratectomy)
- Capsulotomy

2.0 Inspection summary

A short notice, announced inspection was undertaken to KDTC on 30 July 2026 by a senior care inspector, three care inspectors and two pharmacist inspectors and on 31 July 2026 by a senior care inspector and two care inspectors.

RQIA's laser protection advisor (LPA) attended the inspection on 30 July 2026 and reviewed the laser equipment and the laser safety arrangements. Their report containing their findings and recommendations is appended to this report. All recommendations identified in the RQIA's LPA report were addressed either during or following the inspection. Further detail is provided in section 5.2.8 of this report.

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

Examples of good practice were evidenced in respect of the oversight mechanisms in place to provide assurances relating to clinical governance, the management of the patients' care pathway and engagement between teams to enhance the patients' experience of care.

Feedback of the onsite inspection findings was delivered to Mrs Green, registered manager; the group clinical governance manager and the laser protection supervisor (LPS) at the conclusion of the inspection on 31 July 2026.

No concerns were identified in relation to patient safety.

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 reports

One week prior to the onsite inspection the hospital was provided with a list of specific documents, requesting items to be reviewed at the onsite inspection.

During the inspection we spoke with Mr Regan, the medical director, the registered manager, the group clinical governance manager, the day procedure unit manager, the decontamination lead, the lead endoscopy nurse, a senior endoscopy nurse, an endoscopy nurse, a healthcare assistant, the lead ophthalmology nurse, the LPS and briefly with a theatre nurse.

The inspection was facilitated by Mrs Green, registered manager.

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 KDTC by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire.

One patient submitted a response. This respondent indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led. The patient indicated that they were very satisfied with each of these areas of their care and included comments praising the staff and noting their friendly approach.

Fourteen staff submitted questionnaire responses. Staff responses indicated that they felt patient care was safe, effective and that patients were treated with compassion. Eight respondents indicated that they felt very satisfied that care was safe effective, compassionate and that the service was well led. The remaining respondents provided a mixed response with some feeling very satisfied and/or satisfied in respect of safe, effective, compassionate care and with leadership in the hospital. One respondent submitting a neutral response, indicating they were undecided in this regard.

Four staff responses included additional comments indicating appreciation of a positive working environment, job satisfaction and recognised good support from the registered manager. Staff also expressed that they felt confidence in respect of patient safety and staff competency within the hospital. One respondent suggested that improvement would be welcome with regards to staff changing and rest areas.

The inspection team had the opportunity to speak with three patients attending for day procedures. Overall the patients spoke very positively about their experiences in KDTC. Patients spoke of receiving high quality of care throughout their care pathway; from pre-admission consultation to the day procedure itself. Patients appreciated the discharge planning arrangements that provided them with information on their specific procedure and aftercare arrangements. Patients also commented positively in respect of infection prevention and control (IPC) standards and of feeling reassured regarding any future day procedures that they may have.

Patients described staff as friendly and attentive, who sought to ensure patients were as comfortable as possible, and stated that they were well informed at every stage of their care journey. One patient described an encounter with a staff member as 'not particularly helpful'. This was shared with Mrs Green, who gave us an assurance the matter would be responded to following the inspection. Another patient commented that staff communicated well in a discreet and respectful manner and that they were provided with all necessary support during their appointment.

As previously outlined, the inspection team spoke with a number of staff with differing roles and responsibilities. Staff described a positive and supportive working environment and stated they felt staffing levels were safe and sufficient to meet patient needs. Staff confirmed that morale was good with 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 KDTC was undertaken on 16 and 17 July 2025; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Governance and Leadership

Organisational governance

Mr Mark Regan is the responsible individual for Kingsbridge Healthcare Group Ltd (KHG) which has four independent hospitals registered with RQIA, one of which is KDTC. Mrs Green, as registered manager, is the nominated individual with overall responsibility for the day to day management of KDTC.

Where the business entity operating a registered establishment is a corporate body, 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.

Mr Regan undertakes a formal unannounced monitoring visit to the premises every six months in accordance with legislation. The most recent unannounced monitoring visit report, along with identified actions, was available for review. The unannounced quality monitoring report provided a detailed account of Mr Regan's findings, which recognised areas where standards were met and also those areas where action was needed. The unannounced visit outcome report had been shared with Mrs Green in a timely manner and appropriate action taken.

Mr Regan confirmed that he continually monitors the quality of services provided by KDTC via a range of meetings attended by representatives from senior management, the local hospital manager and departmental leads. Mr Regan advised he is also assured by spending time in KDTC and visits the facility on at least a weekly basis.

KDTC as part of the KHG is supported by well-established corporate governance arrangements. The KHG organisational and governance structure is built around the governance and compliance strategy framework with defined lines of accountability at all levels of the organisation. The KHG Quality Improvement Strategy is reviewed annually, providing assurance to the Board that leadership arrangements remain appropriate, current and effective.

Governance and quality teams are organised at local and KHG administration level. The local management team at KDTC meet on a weekly basis with heads of department. The local team report directly to the team at KHG level which meets quarterly. Separate quality and governance teams are in place for compliance and risk, IT, infection prevention and control (IPC), and estates. The KHG governance and quality team collate an annual quality report for board level. Board level oversight is provided by the directors with operational accountability.

In addition, departmental and specialism meetings are held regularly and all relevant staff are required to attend. Minutes of the endoscopy user group meeting were retained. Review of the minutes evidenced that the meeting serves as a forum for open discussion and sharing staff concerns.

KDTC uses a variety of means to share organisational learning with staff to include; discussion at daily safety briefs and handovers; emails; memorandums; posters; and educational events. Discussion with staff members demonstrated that they considered the means of disseminating information to be effective, stating they felt well informed and were confident they were up to date in their knowledge of current policies, procedures and protocols.

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

Clinical and medical governance

A team of consultants who have specialist qualifications and skills in endoscopy and minor surgery work in KDTC. In addition, private GP services are currently available on an appointment only basis.

An established medical advisory committee (MAC) was in place which meets quarterly with responsibility for consultant and surgery specific matters. The MAC operates at KHG group level, thereby sharing information and learning across the four hospital sites.

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 KDTC is registered with the GMC as a designated body and have an appointed RO.

Medical practitioners working in the KDTC submit appraisal documentation and competency declarations via an online portal. Medical practitioners receive automated reminders for any expiring documents. Recent minutes of the MAC detailed that the revalidation of medical practitioners was up to date.

A private doctor is a GMC registered doctor who does not have a prescribed connection to a responsible officer within the Health and Social Care sector in NI.

A review of a sample of four private doctors' details demonstrated 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

We spoke with Mrs Green about the arrangements regarding oversight and recording of on-going training for consultants, to ensure they receive mandatory training and other relevant training in accordance with the legislation, minimum standards and regional policies.

Consultant training days are held periodically through the year and consultants/clinicians are encouraged to avail of this opportunity to keep mandatory training up to date. Records are retained to evidence attendance of consultants and private GPs at these mandatory training days.

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.

Consultants who work in KDTC are not directly employed by the KHG and work under a practising privileges agreement.

A detailed policy and procedure for the granting, review and withdrawal of practicing privileges agreements was in place. It was evidenced that this policy states that 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.

Discussion with the medical director demonstrated that practicing privileges matters, including the approval, restriction or withdrawal of privileges, are discussed confidentially and the outcome is included in MAC meetings.

An electronic tracking system is in place to monitor the status of practising privileges agreements. A review of a sample of records evidenced that there was a written practicing privileges agreement between each private doctor and KDTC, which set out the terms and conditions. It was noted that the practising privileges agreements had been reviewed within the previous two years, each private doctor's scope of practice had been clearly stated, and agreements had been signed by both the doctor and the medical director or the deputy medical director of the KHG.

It was 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.

Significant incidents and themes reported are discussed at the organisation's clinical governance and meetings, medical advisory and health and safety committees.

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 audit schedule. The results are monitored by the local and regional management team and actions identified for improvement are embedded into practice. Where improvement is required, action plans are 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 clinical risks, incidents and near misses and a policy for the management of national safety alerts were in place.

The clinical governance manager provided a detailed overview of KHG's arrangements for the management of incidents and notifiable events. This included a demonstration of the new INSIGHT software package that has been implemented to log and process all accidents, incidents (clinical and non-clinical) and serious adverse incidents (SAIs) where relevant.

When incident/event data is added, INSIGHT will notify Mr Regan, the medical director and other identified senior personnel within KHG.

Once notified the recipients can direct how the event will be managed. Mr Regan, the medical director and the clinical governance lead, described the benefit in efficiency of reporting time, hence enabling relevant personnel to take immediate and appropriate action.

The clinical governance manager also demonstrated the arrangement in place for analysing incidents and events to enable early detection of potential or actual trends or weakness in any area, in order that a prompt and effective response can be considered at the earliest opportunity.

A review of meeting minutes evidence that significant incidents and themes reported are discussed at the organisation's clinical governance meetings, MAC and health and safety committees.

Mrs Green confirmed that any learning from incidents would be communicated to relevant staff within KDTC.

Complaints Management

The complaints procedure was reviewed and found to be in line with the relevant legislation. It was noted that the procedure had been updated to reflect the Model Complaints Handling Procedures (MCHP) issued by the Northern Ireland Public Services Ombudsman (NIPSO) during July 2025. Discussion with the clinical governance manager confirmed that a copy of the complaints procedure is made available for patients and/or their representatives on request and is also available on KHG website.

The clinical governance manager provided a detailed overview of the KHG's complaints management procedure. This included a demonstration of the INSIGHT software package which is also used to log and process all complains received by KHG. Senior members of the KBG, including Mr Regan and the medical director, are notified of all complaints received across the group. It was confirmed that the INSIGHT software is compliant with best practice guidance in terms of timeframes for acknowledging and investigating complaints. INSIGHT provides electronic alerts and a dashboard reminder system to inform and prompt assigned staff to adhere to timeframes of acknowledgement and to provide the complainant with an outcome of the complaint investigation. It was also confirmed that INSIGHT includes a mechanism to monitor complaints that are unable to be progressed in keeping with best practice investigation timeframes, whereby a reminder is in place to ensure the complainant is issued a timely update regarding the delay in providing an outcome of the complaint at that time.

A review of the complaints log evidence that all complaints received since the previous inspection had been recorded, investigated and responded to appropriately to include details of all communications with complainants; the result of any investigation; the outcome and any action taken.

The management of complaints is reviewed on a weekly basis with an overarching quarterly audit of complaints undertaken to identify trends or themes emerging. The quarterly audit of complaints is included as a standing agenda item for the Group Governance and Quality Team and MAC meetings.

It was demonstrated that information gathered from complaints will be used to improve the quality of services provided.

Overall, the governance structures within the hospital provided the required level of assurance to the responsible individual and the Kingsbridge Healthcare Group.

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

Staffing arrangements were reviewed and it was confirmed that appropriately skilled and qualified staff were in place in respect of the services offered.

Mrs Green demonstrated that staff training is managed through the KHG training academy and consultant mandatory training days held throughout the year. All staff are facilitated and encouraged to take part in ongoing training to update their knowledge and skills, relevant to their role.

Consultants working under practicing privileges are required to submit evidence of completed mandatory training. A review of a sample of three consultant's training files evidenced that they had completed and retained evidence of mandatory training.

An electronic matrix provides Mrs Green with oversight of mandatory training compliance for staff directly employed by the clinic. A review of the most recent summary report of compliance demonstrated that staff had either completed or were in the process of completing training as outlined in the RQIA training guidance and legislation.

Staff we spoke to stated there were opportunities to undertake additional training in relation to their work and there was evidence that these matters were discussed and agreed during supervision and appraisal.

Induction programmes relevant to roles and responsibilities are required to be completed when new staff join the team. A review of records confirmed that the newly appointed staff had complete a structured induction and orientation.

Discussion with Ms Green, in conjunction with a review of documentation, confirmed that robust arrangements were in place to check the registration status for all clinical staff on appointment and on an ongoing basis. Arrangements were in place for monitoring the professional indemnity of all staff.

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 Medicines management

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

The management team were requested to prepare a range of documents to support the inspection. The RQIA pharmacist inspectors reviewed these documents.

Medicine management policies and procedures were in place and there was evidence these were routinely reviewed and updated. A system was in place to ensure all staff involved in the management of medicines had read and understood the policies.

Systems were in place to ensure that any updates were communicated to the nursing, pharmacist and medical staff, for example, at Drugs and Therapeutics meetings and staff meetings.

There were safe arrangements in place for the stock control and storage of medicines. Medicines were ordered on requisition forms signed by nurses with separate controlled drug specific requisition forms for the ordering of controlled drugs. Each unit had a controlled drug requisition form book.

Medicines were supplied from the Kingsbridge Independent Hospital pharmacy. There is no pharmacist based on site at the KDTC, however a team of KHG pharmacists provide regular advice and support to the service.

Medicines were stored safely and securely. Controlled drug cabinets and medicine refrigerators were available for use as needed. Temperatures of the medicine refrigerators and storage room areas were recorded daily via an electronic monitoring system and alerts provided if the temperature deviated from the target range. This ensured medicines were stored according to the manufacturers' instructions. Satisfactory arrangements were in place for the safe disposal of medicines.

A number of Patient Group Directions (PGDs) were in place. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber. There was evidence the PGDs in use were used in compliance with legislation and professional standards and were reviewed on an annual basis or when deemed necessary to review earlier.

The management of controlled drugs was reviewed. A controlled drugs policy was in place and satisfactory arrangements for the management of controlled drugs were observed. There is an Accountable Officer (AO) with responsibility for securing the safe management and use of controlled drugs. A planned change to the AO arrangements had been effectively communicated to the Department of Health.

Systems were in place to audit the management of controlled drugs on a quarterly basis and a monthly controlled drug usage audit was completed.

Medicines management training was provided by the Kingsbridge training academy. Systems were in place to ensure this was provided for all staff involved in medicines management, within the mandatory training programme. Additional training included the management of controlled drugs.

The arrangements for reconciling medicines for patients was reviewed. Robust arrangements were in place to ensure the safe management of medicines when a patient was admitted to the hospital. Details of pre-admission medicines were obtained as part of the admission process and recorded on the patient's care pathway document.

Medicines may be supplied to patients as part of the discharge process. Systems were in place for a prescription to be provided to the patient to obtain discharge medication from the Kingsbridge Independent Hospital pharmacy or an alternative pharmacy. Selected medication may be supplied via a PGD upon discharge when the option to obtain a valid prescription is unavailable.

An effective incident reporting system was in place to identify, record, report and share learning from any medicine related incidents should they occur. Staff spoken with were aware of the type of incidents which should be reported to RQIA.

A range of audits was completed to ensure the safe and effective management of medicines, including clinical audits and a quarterly controlled drugs audit completed by the pharmacists, and an Accountable Officer controlled drug audit. An electronic audit tool is used throughout the service for auditing purposes.

Systems were in place for the management of drug and medical device alerts. A record of all alerts received and the actions taken in response was maintained.

5.2.4 How does the service ensure that recruitment and selection procedures are safe?

The arrangements in respect of the recruitment and selection of staff were reviewed.

KDTC is supported by the KHG corporate human resources (HR) shared services department. The corporate HR department assists Mrs Green during the recruitment process. Mrs Green confirmed that she has access to the electronic HR system and can verify that all required recruitment documentation is in place for new staff members prior to commencement of work.

A recruitment policy and procedure was in place which was in keeping with legislation and best practice guidance.

A number of new staff had been recruited since the previous inspection to support service development. A review of a sample of personnel files of staff recruited, confirmed that all information, as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005, had been sought and retained. It was good to note advice provided by RQIA at the previous inspection had led to strengthening of the recruitment process. A system was place to ensure all consultants who work in KDTC now complete a criminal conviction declaration prior to approval of their practising privileges agreement.

Discussions with Mrs Green confirmed she had a clear understanding of recruitment and selection legislation and best practice guidance.

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

5.2.5 Are there safe practices in place for the day surgery and endoscopy services?

We reviewed the arrangements for the provision of day surgery and endoscopy services in the hospital outlined under their statement of purpose and categories of care. The review of day surgery and endoscopy 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 or endoscopy procedures will be co-ordinated by the KHG booking system with the involvement of senior nursing staff.

Scheduling will take into account individual patient requirements, staffing levels, the nature of the procedure and any associated risks.

The patient will be sent 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 room or endoscopy suite.

There will be an identified member of nursing staff, with relevant experience, in charge during all procedures. Staff will complete a surgical safety checklist based on 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. 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.

Surgical registers are maintained for all procedures undertaken in the hospital. It was advised to ensure the full name of staff nurses involved in the surgery or endoscopy procedures is recorded in the surgical registers.

Five completed patient records relating to day surgery patient care pathways, endoscopy patient care pathways and ophthalmology patient care pathways were reviewed. Records were found to provide a framework for the clear record of admission, medical history, consent, IPC status, medication, observations on admission, pre-procedure checklist, surgical safety checklist (WHO), intra-procedure details, traceability details, post procedure observations and discharge record. However, one patient record did not have a written consent form in place. Management confirmed it was an oversight and gave assurances on the matter. There was discussion with staff on the management of intra-operative fluids such an irrigation fluid used during some endoscopy procedures. Whilst some details were recorded of the intra-operative irrigation fluids, it was advised to ensure full details are recorded in the patient record. Advice was also provided to review and audit patient records to ensure they are fully completed. Staff and management were receptive to this advice.

Medical emergencies were discussed with surgical staff including the management of a massive blood loss emergency. Staff confirmed that the range of surgical and endoscopy procedures currently carried out are considered low risk in relation to a massive blood loss emergency. The KHG medical director has decided that, given the nature and scope of surgical procedures performed at KDTC, the introduction of a separate massive blood loss tray would not add significant benefit in this setting at this time. It was stated that KDTC would review the need for additional measures, should the surgical service evolve in a way that increases the risk of significant blood loss.

Management and staff confirmed that a prevention of venous thromboembolism (VTE) assessment is carried out and preventive measures prescribed as necessary by the consultant surgeon.

There was a procedure for the collection, labelling, storage, preservation, transport and administration of specimens. Staff clearly described detailed procedures for the management of specimens and the procedure for reporting results to the appropriate clinical staff and GPs, which was fully reflected in the current written procedure. It was confirmed there is a contract in place with a pathology laboratory service. The pathology services are subject to internal audit.

KDTC have an onsite endoscopy decontamination suite for the decontamination of endoscopes used within KDTC. The endoscopy decontamination process was clearly described by the decontamination lead and the comprehensive electronic record of this pathway was reviewed. It was found to be well understood and completed by suitably qualified and trained staff. The decontamination process is subject to a rolling programme of robust audits including a weekly internal audit and a three-monthly unannounced audit by the sterile services manager who is based in the sterile services department within Kingsbridge Private Hospital North West (KPHNW).

KPHNW has an EN ISO 13485 certified hospital sterilisation and decontamination unit (HSDU) on site. This HSDU supplies sterile instruments packs for surgical procedures to KDTC. There are robust measures in place to monitor traceability of all surgical instruments used in the hospital.

Clinical equipment was evidenced to be clean and fit for purpose and traceability labels were used to identify when equipment has been cleaned.

It was determined that there were safe practices in place for the day surgery and endoscopy services.

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

The arrangements in respect of the management of medical emergencies were reviewed. KDTC has policies and procedures in place for dealing with medical emergencies.

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

It was confirmed that two emergency trollies are in place; one is located centrally on the ground floor and the other on the first floor ensuring that all staff have immediate access to appropriate drugs and equipment in the event of a medical emergency.

Systems were in place to ensure that emergency medicines and equipment do not exceed their expiry date. A check list was provided with each trolley that itemised both the contents of each drawer and the equipment stored on the top. An anti-tamper seal was in place.

The automated external defibrillator, oxygen cylinder and suction machine are checked daily. Pharmacy also conduct quarterly checks of controlled drugs.

It was identified that there was a means of calling for help in an emergency. This includes a nurse call button system for which there is an alarm display screen located at the nurses' station. This alarm is tested daily. There were also red desktop emergency telephones in place.

A review of training records evidenced that the consultant and all nursing staff had completed immediate life support (ILS) and all other staff for basic life support (BLS). A number of staff have advanced life support (ALS) and at least one member of staff with ALS is available in the hospital when patients are present.

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

5.2.7 How does the service ensure that it adheres to infection prevention and control (IPC) and decontamination procedures?

The arrangements for IPC procedures throughout the hospital were reviewed to evidence that the risk of infection transmission to patients, visitors and staff was minimised. It was confirmed that a range of IPC policies and procedures were in place that were in keeping with best practice guidance and include outbreak management, notifiable diseases, transmission precautions, prevention, control and surveillance, cleaning, disinfection and sterilisation.

A tour of the premises was undertaken and the hospital was found to be clean, tidy, uncluttered and finished to a high standard of décor. Staff described the arrangements to decontaminate the environment and equipment between patients in keeping with best practice.

It was confirmed that the majority of equipment used is single use where possible.

Cleaning schedules were in place and staff are advised on the appropriate disinfectant and cleaning process to use for equipment between each patient usage.

As discussed previously endoscopes are decontaminated on site by appropriately trained and competent staff; and sterile surgical instruments are supplied from KPHNW's certified HSDU.

Personal protective equipment (PPE) was readily available in keeping with best practice guidance. Waste management arrangements were in place and clinical waste bins were pedal operated in keeping with best practice guidance.

The treatment rooms and consultation rooms provided dedicated hand washing facilities and hand sanitiser was available throughout the hospital.

It was confirmed that staff have access to an external IPC nurse consultant and each department has an IPC champion. There is also access to a microbiologist should advice be required and Public Health Agency (PHA) details are available for staff.

It was confirmed that KDTC staff are part of the KHG 'Hospital Infection Control Steering Group'. There is planned monitoring and measuring of IPC practices to reduce the risk of health care associated infections (HCAI). A review of records confirmed that a range of IPC audits are carried out and findings shared.

As previously discussed staff training records confirmed that staff have completed IPC training commensurate with their roles and responsibilities. It was confirmed that a training programme of Aseptic Non-Touch Technique (ANTT) has been implemented for relevant staff.

The KDTC management and staff demonstrated good knowledge and understanding of IPC procedures.

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

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

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

A laser safety policy and procedure is in place.

A review of the laser safety files found that they contained all of the relevant information in relation to all the laser equipment in place. There was written confirmation of the appointment and duties of a certified LPA which will be reviewed on an annual basis. The service level agreement between KDTC and the LPA is due for renewal during February 2027.

It was confirmed that laser and refractive eye procedures are carried out by the consultant ophthalmologists, acting as the authorised operators. The consultant who undertakes refractive eye procedures is assisted by a laser technician acting as non-clinical authorised operator.

A register of clinical and non-clinical authorised operators for the lasers is maintained and kept up to date.

The clinic's LPA completed a review of the laser risk assessment during April 2026 and provided a laser safety report. Any actions identified by the LPA had been addressed.

Laser and refractive eye procedures are carried out in accordance with medical treatment protocols produced by a consultant ophthalmologist and systems were in place to review the medical treatment protocols on an annual basis. It was noted that the YAG treatment protocols required a document control process, including version numbers and review dates. Guidance was provided to the LPS in this regard and the matter was addressed on 31 July 2026.

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 equipment being used and all appropriate clinical authorised operators had signed to state that they had read and understood these. The LPS was advised to ensure that the non-clinical authorised operator signed to confirm they had read and understood the local rules. This matter was addressed on 31 July 2026.

The LPS was advised to review the local rules as some minor amendments were required to reflect the local arrangements. The LPS provided assurances this matter would be addressed following the inspection.

LPS confirmed that she is aware that when the laser equipment is in use, the safety of all persons in the controlled area is her responsibility. Arrangements were in place for another authorised operator to deputise for the LPS, in her absence, who is suitably skilled to fulfil the role.

A review of training records confirmed that all clinical and non-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.

It was evidenced that dedicated laser surgical registers are maintained every time the lasers are operated to include:

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

Whilst the registers were mostly correctly completion, on occasion some records were not fully complete. The LPS provided assurances this matter would be addressed following the inspection.

The Zeiss laser suite and the Lumenis Aura PT YAG laser treatment room, known as controlled areas, were found to be safe and controlled to protect other persons whilst treatment is in progress. The LPS confirmed that the doors to the controlled areas are locked when the laser equipment is in use and can be opened from the outside in the event of an emergency.

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

Protective eyewear was available for non-clinical authorised operators if required. A review of the eyewear evidenced that it was available as outlined by the LPA in the local rules.

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

Discussion with the LPS identified that arrangements have been established for the equipment to be serviced and maintained in line with the manufacturers' guidance.

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.

It was determined that the action taken by KDTC in response to advice provided during this inspection has strengthened the arrangements for the safe operation of the laser equipment.

5.2.9 Equality Data

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

Discussion and review of information evidenced that the equality data collected will be managed in line with best practice.

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Green, Registered Manager; the group clinical governance manager; and the lead ophthalmology nurse, as part of the inspection process and can be found in the main body of the report.

Appendix 1

13 August 2026

Laser Protection Report

Site Details:
Kingsbridge Diagnostic and Treatment Centre
Kings Hall Life Science Park
Upper Lisburn Road
Belfast
BT9 6TW

Laser Equipment:

Make	Model	Class	Serial Number	Wavelength
Lumenis	Aura PT	3B	YA44-0165	1064nm Nd:YAG)
Zeiss	Visumax 800	3	9511100388	1043nm
Zeiss	Mel 90	4	9507700033	193nm (ArF)

Introduction
A Laser Protection Adviser inspection of Kingsbridge Diagnostic and Treatment Centre was performed on 30 July 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, with staff demonstrating an appropriate awareness of laser safety requirements and local procedures. Only minor areas of improvement were identified during the inspection to ensure that local documentation remains accurate, current, and reflective of clinical practice.

1. Local Rules

a) A review of the local rules for the Mel 90 laser identified a requirement for a six-monthly visual inspection of the laser gas cylinder. However, discussions with clinic staff confirmed that the gas cylinder is not accessible to local users and therefore the specified inspection cannot be carried out. Staff advised that the laser undergoes annual servicing by the service engineer, during which relevant checks are undertaken.

The clinic should contact its Laser Protection Adviser (LPA) to review this requirement and amend the local rules as appropriate.

b) All of the local rules documents contained references to appendices that were not present within the documents reviewed. It was noted that these appendices appear to have been replaced by separate local documentation. Whilst the required information may be available elsewhere, the current references could result in inconsistencies between documented and actual practice.

The clinic should undertake a review of the local rules in consultation with the LPA to ensure that all references are correct, that obsolete appendix references are removed or updated, and that local practices and supporting documentation are accurately reflected within the controlled documents.

2. YAG Treatment Protocols

a) A review of the YAG treatment protocols identified evidence that the protocol is subject to periodic review, with a completed review timetable demonstrating that updates have been undertaken. However, the protocol document itself did not contain version control information, such as a version number, or revision date. As a result, it was not possible to verify that the copy held within the laser safety file was the current approved version.

The clinic should implement an appropriate document control process for YAG treatment protocols, including the use of version numbers and review dates.

b) The YAG treatment protocols contained a reference to reporting medical device incidents to Northern Ireland Adverse Incident Centre (NIAIC). Following recent changes to reporting arrangements, medical device incidents should now be reported directly through the MHRA Yellow Card reporting scheme.

The clinic should update the YAG treatment protocols to reflect the current reporting pathway.

3. Treatment Register: Whilst most records were correctly filled in, some records were not fully complete. The clinic should remind users of the importance of completing all fields in the laser register.

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

Laser Protection Adviser to RQIA





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