Inspection Report

24 June 2026



Jace Medical

Type of service: Independent Hospital
Address: Units 1, 2, 9 & 10 The Vale Centre, Clooney Road, Greysteel, Londonderry, BT47 3GE
Telephone number: 028 7116 5790

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: J.J.A.C.E. LTD **Responsible Individual:** Dr John Doherty	**Registered Manager:** Ms Delma McCurry **Date registered:** 25 November 2024
Person in charge at the time of inspection: Ms Delma McCurry	
Categories of care: Acute Hospital (Day Surgery) - AH(DS) Private Doctor - PD Endoscopy - PT(E)	
Brief description of how the service operates: Jace Medical is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital with the following categories of care; prescribed techniques or prescribed technology: establishments providing endoscopy services PT (E); private doctor (PD) and acute hospitals (day surgery only) AH (DS). Jace Medical provides a range of services and treatments, including outpatient services across a range of medical specialties; diagnostic tests and investigations and surgical day case procedures.	

2.0 Inspection summary

A short notice announced inspection was undertaken to Jace Medical on 24 June 2026 from 10.00 am to 5.30 pm by three care inspectors and on 2 July 2026 from 10.30 am to 3.10 pm by two pharmacist inspectors. Findings were shared with Ms McCurry, Registered Manager, during both inspections. Feedback was also provided virtually to Dr Doherty and Ms McCurry on 1 July 2026 and 3 August 2026 by the care and pharmacist inspectors respectively.

This inspection focused on four main key themes: organisational and clinical governance; the safe practice for provision of endoscopy and day surgery services, staffing arrangements and the management of medicines. The inspection also assessed progress with the areas for improvement identified at the last care inspection on 30 and 31 July 2025.

A detailed review of the four main key themes as outlined above identified issues of concern in relation to each of these areas.

RQIA was concerned that the deficits highlighted during the inspection had not been identified internally by the responsible individual. As a consequence of the inspection findings, RQIA invited Dr John Doherty, Responsible Individual, to attend two meetings in RQIA on 17 July 2026, with the intention of issuing two Failure to Comply (FTC) notices under The Independent Healthcare Regulations (Northern Ireland) 2005 and the intention of serving a Notice of Proposal to place a condition on the registration of the establishment.

The meetings were attended by Dr Doherty and Ms McCurry. At the meetings, an action plan which detailed an account of the actions that had been taken to date was provided and the arrangements that had been made to ensure the improvements necessary to achieve full compliance with the required regulations were discussed. However, the representatives were unable to offer RQIA full assurance, as a number of areas required time to ensure that new processes were fully embedded into practice.

It was therefore decided that both FTC notices would be issued with the date of compliance to be achieved by 21 October 2026:

- FTC Ref: FTC000260 with respect to Regulation 13 (1)
- FTC Ref: FTC000261 with respect to Regulation 18 (1) and (2)

A notice of proposal to impose conditions on the establishment was not issued. The registered persons agreed that Jace Medical will not undertake any surgical list involving general anaesthesia or any endoscopy procedures without the prior written authority of RQIA.

Enforcement notices for registered establishments and agencies (with the exception of children's services) are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity

In addition to the FTC notices, five new areas for improvement have been identified. Three of the eleven areas for improvement identified at the previous inspection were evidenced as met. Eight areas for improvement were not met, two have been stated for a second time and the remaining six areas have been subsumed into FTC notices. Details of the areas of improvement are included in the below Quality Improvement Plan (Section 6.0)

RQIA would like to thank staff and management for their assistance and co-operation during this inspection process.

3.0 How we inspect

RQIA is required to inspect registered services in accordance with legislation. To do this, we gather and review the information we hold about the service, examine a variety of relevant records, meet and talk with staff and management and observe practices on the day of the inspection.

Prior to the inspection we reviewed a range of information relevant to the hospital.

This included the following records:

- notifiable events since the previous care inspection
- the registration status of the hospital
- written and verbal communication received since the previous care inspection
- the previous care inspection report

The inspection team undertook a tour of the premises and Ms McCurry facilitated the inspection. No other staff members were available.

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 Jace Medical by RQIA prior to the inspection inviting clients and staff to complete an electronic questionnaire. No completed client or staff questionnaires were submitted to RQIA prior to the inspection.

5.0 The inspection

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

5.2 Inspection findings

Areas for improvement from the last inspection on 30 and 31 July 2025		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 21 (1) , (3) Schedule 3 Part 11 (2) **Stated:** First time	The responsible individual shall ensure the endoscopy surgical registers are appropriately completed and routinely audited to ensure compliance.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement was not met and has been subsumed into the FTC Notice FTC000260. See Section 5.2.1	

Area for Improvement 2 **Ref:** Regulation 21 (1) **Stated:** First time	The responsible individual shall ensure patient records are fully completed as outlined in section 5.2.1 and shall implement a robust patient record audit.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement was not met and has been subsumed into the FTC Notice FTC000260. See Section 5.2.1	
Action required to ensure compliance with Minimum Care Standards for Independent Healthcare Establishments (July 2014)		
Area for Improvement 1 **Ref:** Standard 32.1 **Stated:** First time	The responsible individual shall ensure the surgical safety checklist based on World Health Organisation (WHO) guidance is in place, consistently completed in patient records and completion is robustly audited through the hospital's auditing programme.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement was not met and has been subsumed into the FTC Notice FTC000260. See Section 5.2.1	
Area for Improvement 2 **Ref:** Standard 32.11 **Stated:** First time	The responsible individual shall ensure there are adequate numbers of appropriately trained staff in recovery area to provide safe care.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement was not met and has been subsumed into the FTC Notice FTC000261. See Section 5.2.2	

Area for Improvement 3 **Ref:** Standard 34 **Stated:** First time	The responsible individual shall ensure robust and accurate recording of pathology specimens and the implementation of a robust pathology audit.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement was not met and has been subsumed into the FTC Notice FTC000260. See Section 5.2.1	
Area for Improvement 4 **Ref:** Standard 13.3 **Stated:** First time	The responsible individual shall ensure that any person working in Jace Medical completes an induction programme relevant to their role and responsibilities within the hospital.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement was not met and has been subsumed into the FTC Notice FTC000261. See Section 5.2.2	
Area for Improvement 5 **Ref:** Standard 25 **Stated:** First time	The responsible individual shall ensure individual staff receive training and competency assessment on medicines management as part of their induction, and refresher training in accordance with the hospital's mandatory training programme.	**Not met**
	Action taken as confirmed during the inspection: Review of training records indicated that competency assessments were not in place, and three out of eight staff had not received medicines management training or their training had expired. **This area for improvement is stated for a second time.** See Section 5.2.3	

Area for Improvement 6 **Ref:** Standard 28 **Stated:** First time	The responsible individual shall ensure that a list of each patient's currently prescribed medication is available within their medicines record.	**Met**
	Action taken as confirmed during the inspection: A list of each patient's currently prescribed medication was available within their admission notes. See Section 5.2.3	
Area for Improvement 7 **Ref:** Standard 28 **Stated:** First time	The responsible individual shall ensure that a record is maintained of the name, strength and quantity of all medicines supplied at discharge.	**Met**
	Action taken as confirmed during the inspection: A record book was available to facilitate accurate recording of medicines supplied at discharge. Assurances were provided that medicines supplied at discharge were packaged and labelled appropriately. See Section 5.2.3	
Area for Improvement 8 **Ref:** Standard 26 **Stated:** First time	The responsible individual shall implement a date checking system to ensure that medicines do not remain in use after their expiry.	**Met**
	Action taken as confirmed during the inspection: A date checking system had been implemented; all medicines were observed to be within their expiry date. See Section 5.2.3	

Area for Improvement 9 **Ref:** Standard 26 **Stated:** First time	The responsible individual shall ensure that the temperature of the medicine refrigerator and storage areas are monitored daily to ensure that medicines are stored at the manufacturer's recommended temperature.	**Not met**
	Action taken as confirmed during the inspection: Room temperatures were not monitored and recorded. Satisfactory systems were not in place for monitoring the temperature of the medicine refrigerators. **This area for improvement is stated for a second time.** See Section 5.2.3	

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

We reviewed the arrangements for the provision of endoscopy and day surgery in the hospital as outlined in their statement of purpose and categories of care. It was confirmed that the hospital provides endoscopy and day surgery services largely under local anaesthesia or intravenous sedation. A small number of surgical procedures have been provided under general anaesthetic (GA) which is further discussed in this section of the report.

The scheduling of patients for endoscopy and day surgery procedures is co-ordinated by Jace Medical management. Scheduling will take into account individual patient requirements, staff availability, the nature of the endoscopy and day surgery procedures and any associated risks. However, it was noted that there had been challenges scheduling endoscopy procedure lists and surgical lists due to lack of suitably trained and competent endoscopy nurses and theatre nurses. In addition, there is no lead theatre nurse/ theatre manager in place to ensure robust oversight by a suitably trained and skilled individual of the endoscopy and surgical procedures. Staffing is further discussed in section 5.2.2 of this report.

The patient is sent information about the procedure and any preparation necessary in advance, together with the consent form. Patients will be admitted to an individual cubicle within the admission/recovery bay.

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

Whilst a surgical safety checklist based on World Health Organisation (WHO) guidance was in place, it was noted to be inconsistently completed and compliance had not been routinely robustly audited through the hospital's auditing process.

The previously identified area for improvement in relation to ensuring the WHO checklist is completed in line with best practice and robustly audited to ensure compliance was assessed as not met and has been subsumed in the FTC Notice FTC000260.

It was confirmed that patients are observed during and after the endoscopy or day surgery procedure carried out under local or intravenous sedation by appropriately trained staff. However, in respect of day surgery under GA it was noted that the staffing levels in the recovery area did not reflect the staffing levels required for this type of anaesthetic. The previously identified area for improvement in relation to ensuring adequate numbers of appropriately trained staff in the recovery area was assessed as not met and has been subsumed in the FTC Notice FTC0002601.

Patients are discharged by nursing staff in accordance to the hospital's agreed discharge criteria. 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.

The endoscopy and surgical registers reviewed had not been completed to the required standard. Duplicate recordings of procedures had been made across surgical registers and an endoscopy procedure performed had not been recorded in the endoscopy register. Staff details, including the scrub nurse and anaesthetist present (when a patient had received a general anaesthetic) were not always completed in the appropriate register. RQIA has concerns around the thoroughness of clinical record keeping and the potential risk this poses to patient safety. The previously identified area for improvement in relation to the completion and routine audit of the endoscopy and surgical registers evidenced was assessed as not met and has been subsumed in the FTC Notice FTC000260.

Supplies of sterile instrument packs and reprocessed endoscopes are obtained from an approved sterile services department under contract from a health and social care trust. There are 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 sample of five day surgery patient care pathways and endoscopy patient care pathways were reviewed. They were found to provide a framework to record admission, medical history, infection prevention and control status, medication, observations on admission, pre-procedure checklist, venous thromboembolism (VTE) assessment, WHO surgical checklist, intra-procedure details, traceability details, post procedure observations and a discharge record. However, it was identified a patient with a documented penicillin allergy did not have a completed allergy alert sticker. WHO surgical safety checklists had not been completed consistently and multiple versions of the checklist were in circulation. Operation notes were not always available within patient records, and recovery documentation and VTE risk assessments had been completed inconsistently. In addition, two versions of the discharge checklist were in use, and a number of the records reviewed had not been fully completed. The previous inspection identified two areas for improvement in relation to ensuring patient care records are fully completed and a robust patient record audit is implemented. These areas were assessed as not met and have been subsumed in the FTC Notice FTC000260.

It was confirmed there is a contract in place with a pathology laboratory service. A review of the arrangements for pathology services in Jace Medical evidenced that pathology and specimen collection logs were completed inconsistently. Specimens collected during procedures were not recorded as witnessed by two staff as per hospital procedure. RQIA are not assured robust arrangements for pathology services are in place to maintain specimen traceability, protect patient information and mitigate the risk of error. The previously identified area of improvement in relation to ensuring robust and accurate recording of specimens and a robust pathology audit is implemented was assessed as not met and has been subsumed in the FTC Notice FTC000260.

An emergency trolley is located in Unit 9/10 and checked daily by nursing staff. Emergency medicines, oxygen and equipment were all in date and clear stock control is in place. Medical emergencies were discussed including the management of a massive blood loss emergency in relation to the type of surgical and endoscopy procedures provided. A massive blood loss policy and procedure and a massive blood loss tray were in place.

A range of policies and procedures were in place to ensure that safe and effective care is provided to patients.

The frequency of theatre and endoscopy lists was discussed and as previously highlighted due to staffing challenges there can be lengthy periods between operating lists. The ongoing maintenance of the theatre suite during these periods of non-use was examined. Whilst some ad hoc arrangements were described such as a health care assistant carrying periodic cleaning, there was no written ongoing programme of maintenance in place which included such matters as scheduled cleaning, the ventilation systems and surveillance of water temperatures. An area of improvement has been identified to devise and implement a robust programme of maintenance for the theatre suite during lengthy periods of non-use and ensure a record is made evidencing the implementation of the programme.

Significant shortcomings were identified regarding the lack of robust managerial oversight and governance of the provision of endoscopy and day surgery in the hospital. This lack of governance and oversight has the potential to place patients at risk. Dr Doherty was required to ensure an effective, comprehensive and meaningful quality monitoring report is completed fortnightly which reviews and monitors progress with the actions specified in Failure to Comply Notices FTC000260 and FTC000261.

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

A staff register was available to review and was found to contain staff details. It was noted that some entries did not have the actual date of commencement recorded. Following the inspection, RQIA received confirmation that this matter had been addressed. However as this matter had also been raised during the previous inspection this area has been subsumed in the FTC Notice FTC000261.

The staff register evidenced that a number of staff had been recruited in a ‘bank’ capacity since the last RQIA inspection.

The personnel files of three newly recruited staff members were reviewed and evidenced that all of the information required by legislation was obtained and retained in the file, with the exception of evidence of professional qualifications. Advice and guidance was provided to Ms McCurry.

Recruitment challenges were discussed with Dr Doherty and Ms McCurry who confirmed that Jace Medical has been unable to recruit any permanent nursing staff and relies on bank and agency nursing staff, which presents challenges when arranging theatre lists requiring staff to have specific role related training. For example, an endoscopy procedure theatre list requires the theatre nurse to have completed endoscopy training.

A review of staff training records confirmed all staff have received basic life support training within the last year. With the provision of surgical procedures under GA, the availability of at least one member of staff with advanced life support (ALS) training was discussed. It was confirmed that the consultant anaesthetist has completed ALS training. However as they may be engaged in the delivery of GA to patients, it was advised that additional staff undertake ALS training. The previously identified area for improvement in relation to ensuring that there are appropriately trained staff in the recovery area to provide safe care was assessed as not met and has been subsumed in the FTC Ref: FTC000261.

A review of duty rota and theatre log records evidenced that on two occasions two nursing staff who had not completed the recruitment process had worked in the Jace Medical theatre. This matter was discussed with Ms McCurry during the inspection and subsequently with Dr Doherty following the inspection and at the FTC intention meeting. All staff working within Jace Medical must be recruited and employed in accordance with statutory legislation and mandatory requirements. This includes the receipt and review of a satisfactory AccessNI enhanced disclosure check prior to commencement of employment. This matter has been subsumed in the FTC Notice FTC000261.

The previously identified area for improvement in relation to staff completing a robust induction programme relevant to their role and responsibilities within the hospital was assessed as not met and has been subsumed in the FTC FTC000261.

It was confirmed that there is a 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 there are significant challenges for the service to ensure appropriate staffing levels are in place to meet the needs of the patients. Complying with the FTC Notices will ensure that staff are suitably recruited and trained to carry out their duties.

Shortcomings in ensuring the provision of appropriately qualified and skilled staff, and in implementing robust recruitment processes in keeping with legislation has the potential to place patients at serious risk. Actions required to implement and sustain improvements have been included in FTC Notice FTC000261.

5.2.3 Medicines management

Written policies and procedures for the management of medicines, including controlled drugs, were in place. However, the Standard Operating Procedures for controlled drugs did not include the procedures for prescribing and administration. The Department of Health Guidance on Standard Operating Procedures for controlled drugs was shared with the Dr Doherty following the inspection. An area for improvement was identified.

The Accountable Officer was responsible for the management of controlled drugs and related governance issues; the Accountable Officer for Jace Medical is the registered manager and this was reflected in the controlled drugs policy.

Satisfactory arrangements were in place for the storage, security and recording of controlled drugs. Records of disposal of part used ampoules were maintained and stock balances were reconciled at the start and end of each shift when the theatre or procedure room were in use.

The hospital had recently experienced difficulty in obtaining stock of a controlled drug. As detailed in the minutes of a recent Medicines Advisory Committee (MAC) meeting in order to minimise wastage it was agreed that a single-use ampoule of a Schedule 2 controlled drug should be divided between patients. Review of the controlled drug record book indicated that this practice had also occurred previously. The sharing of the contents of a controlled drug ampoule between patients is poor practice and must be avoided. In addition, this practice may sit outside the terms of the product licence. Dr Doherty and Ms McCurry, Accountable Officer, must ensure that controlled drugs are administered in accordance with controlled drug legislation, Summary of Product Characteristics, product licence, professional standards and published guidance. An area for improvement was identified.

Clinical governance arrangements for medicines management were reviewed. The minutes for the last three MAC meetings indicated these meetings had been attended by Dr Doherty and Ms McCurry only. A range of medicine audits were carried out, including a quarterly controlled drugs audit, reconciliations of medicines ordered, received and administered, date checking, clinical room checks and emergency trolley checks. Audits of clinical records were discussed with Ms McCurry who reported that implementing the actions from audits was difficult due to lack of regular staff and infrequent clinics. The benefit of implementing a more robust audit, which includes on-going review of the Quality Improvement Plan, was discussed with Dr Doherty and Ms McCurry and is included in FTC Notice FTC000260 relating to the governance and oversight of the establishment by the registered person.

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

Ms McCurry advised that an effective incident reporting system was in place to identify, record, report and share learning from any medicine related incidents; no incidents had been reported to RQIA since the last inspection. Ms McCurry was reminded that incidents involving controlled drugs must be reported to the Local Intelligence Network.

Ms McCurry advised that there were no core/permanent nursing staff. Medical staff and bank nurses were responsible for ensuring that their medicines management training was up to date and were asked to read Jace Medical policies and procedures relating to medicines management as part of their induction. However, as identified at the last inspection, training on medicines management specific to Jace Medical was not provided for nurses and doctors as part of their induction; and refresher training had not been provided in accordance with the hospital's mandatory training programme. Competency assessments were not available. An area for improvement identified at the last inspection has been stated for a second time.

The arrangements for reconciling medicines prior to any treatment, including day procedures was reviewed. Details of currently prescribed medicines were obtained as part of the patient's initial consultation and prior to all day procedures; a list of each patient's currently prescribed medicines was maintained in their medical notes.

The personal medication records (kardexes) selected for review were well maintained and included the patient's allergy status. Each patient's weight and venous thromboembolism risk (VTE) was also recorded. Records reviewed indicated medicines were being administered as prescribed (See also Section 5.2.1).

Review of patients' notes indicated that records of medicines supplied at discharge were maintained. Ms McCurry provided assurance that medicines supplied at discharge were packaged and labelled appropriately.

Medicines were requisitioned from a wholesaler and a local community pharmacy by designated staff only. Separate requisition and receipt records were in use for general medicines and controlled drugs. Medicine invoices were filed separately from other invoices and matched to order records to facilitate audit. Discussions indicated that a hospital formulary specific to Jace Medical, including minimum stock levels was not in place. Systems should be in place to manage the ordering of prescribed medicines to ensure adequate supplies of all required medicines are available and to prevent wastage. An area for improvement was identified.

Medicine storage areas were observed to be clean, tidy and organised. Medicines were stored safely and securely in the locked cupboards within the theatre and procedure room. However, medicines for one consultant were observed on a bench in an unlocked room. Dr Doherty provided assurances (3 August 2026) that a locked medicine cabinet was now in place.

Medicines which require cold storage must be stored between 2°C and 8°C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. For one refrigerator, only the current temperature was monitored each day; this does not provide evidence that the temperature is maintained within the required range at all times. In addition, the temperature of the medicines storage areas were not monitored. An area for improvement identified at the last inspection was stated for a second time.

A robust date checking system was in place to ensure that medicines did not remain in use after their expiry. Appropriate arrangements were in place for the safe disposal of medicines including controlled drugs.

5.2.4 Organisation and clinical governance

A defined organisational and management structure with defined lines of responsibility and accountability was in place.

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. It was confirmed that Dr Doherty is present in the establishment on an ongoing basis and is involved in the delivery of day surgery services, therefore six monthly unannounced quality monitoring visits are not required.

As previously outlined, significant shortcomings were identified regarding the lack of robust managerial oversight and governance of the provision of endoscopy and day surgery procedures in the hospital and also the lack of appropriately qualified and skilled staff in place to meet the needs of the patients and services provided. This was included in Failure to Comply Notice FTC000260.

During the inspection it was identified that a clinician had recorded a matter for the attention of Dr Doherty within theatre records, however there was no evidence to verify that the matter had been brought to the attention of Dr Doherty, nor if appropriate action had been taken. An area for improvement has been identified against the standards to establish a clear protocol that will enable staff to escalate any matter of concern for the attention of Dr Doherty and/or Ms McCurry. Records should be retained in this regard.

Policies and procedures were available for staff reference and discussion with Ms McCurry confirmed that a structure is in place to ensure that policies are being reviewed in a systematic manner. Ms McCurry confirmed that policies are easily accessible by staff.

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. However, it has been confirmed that diagnostic day case services are not required to register with PHIN at this time.

Clinical and Medical Governance

A small team of consultant surgeons who have specialist qualifications and skills work in Jace Medical.

Clinical governance within Jace Medical is overseen by the MAC. 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, review of any 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 ant estate management matters.

These meetings were being undertaken on a quarterly basis in line with the criteria set out in Standard 30. As Jace Medical is a small organisation, MAC meetings are generally attended by Dr Doherty and Ms McCurry only. Following the inspection Dr Doherty informed us that a MAC meeting had taken place with the consultants in attendance thereby providing an enabling environment for open discussion around clinical matters.

Discussion with Ms McCurry and a review of records confirmed that arrangements are in place to monitor individual consultant's professional indemnity, annual appraisal and registration status with the General Medical Council (GMC). Dr Doherty confirmed that he is responsible for reviewing each consultant's annual appraisal. A process was in place to monitor receipt of each consultant's annual appraisal.

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 clinic have a designated RO. Dr Doherty has established links with ROs of the doctors working in the organisation should a concern arise.

One consultant is considered to be a wholly private doctor as they are not affiliated with the HSC sector in Northern Ireland (NI) and are not on the Primary Medical Performers List (PMPL) in NI. The following was confirmed:

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

Whilst it is the responsibility of GMC registrants to keep up to date with their continuing professional development (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.

We reviewed the arrangements for the oversight and recording of induction and on-going training for consultants to ensure all consultants working in Jace Medical complete mandatory and other training in accordance with best practice guidance. Discussion with Ms McCurry 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. Some deficits were noted in respect of staff completion of mandatory training. This was included in FTC Notice FTC000261.

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 McCurry informed us that all medical practitioners working in Jace Medical are not directly employed and therefore have a practising privileges agreement in place.

A detailed policy and procedural guidance for the granting, review and withdrawal of practicing privileges agreements was in place. This procedure includes the practicing privileges applicant having an interview/meeting with the medical director or the registered manager.

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. It was noted that the practising privileges application also includes a requirement to demonstrate completion of specific areas of mandatory training and provide a copy of their annual appraisal document within a specific time frame.

A review of records evidenced that there was a written practicing privileges agreement between each consultant and Jace Medical, setting out the terms and conditions. It was also evidenced that the practising privileges agreements in place, clearly stated each consultant's scope of practice.

Ms McCurry was aware that practising privileges agreement should be reviewed at least every two years.

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

Ms McCurry was advised that the Jace Medical website should provide information on consultants' eligibility for the granting of practising privileges in Jace Medical.

Discussion with the Ms McCurry demonstrated that good oversight arrangements of the granting of practicing privileges agreements were in place.

Quality Assurance

Whilst arrangements were in place to monitor, audit and review the effectiveness and quality of care and treatment delivered to patients at appropriate intervals, these were not effective and failed to identify the significant shortcomings as outlined within this report.

As previously stated, Dr Doherty is required to implement robust audit and quality assurance systems to monitor compliance across all aspects of care and service delivery, including the management of medicines. This area will be reviewed at the next RQIA care inspection.

It was confirmed that a system was 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 McCurry confirmed that any learning from incidents would be discussed with staff.

There was a process in place for analysing incidents and events 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.

During discussion it was confirmed that any significant incident and/or themes reported will be reviewed by Dr Doherty and discussed at the 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.

Ms McCurry 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.

A review of the complaints audit confirmed that no complaints have been received since the previous RQIA inspection. Ms McCurry stated that should a complaint be received this will be investigated and responded to appropriately to include details of all communications with complainants; the result of any investigation; the outcome and any action taken. It was confirmed that any learning coming out of a complaint will be disseminated across all staff groups to drive quality improvement of this service.

The management of complaints is reviewed on an ongoing basis with an over-arching quarterly audit of complaints undertaken to ensure any trends or themes emerging will be identified at an early stage. The quarterly 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 to provide assurance about the effective identification and management of risk. The content of the risk register had been discussed with Dr Doherty at the previous inspection in July 2025, who was satisfied that all risks in connection with the establishment, treatment and services were identified, assessed and managed. This matter was not directly reviewed during this inspection process.

6.0 Quality Improvement Plan/Areas for Improvement

As stated above, enforcement action resulted from the findings of this inspection. Two failure to comply notices were issued on 21 July 2026 under The Independent Health Care Regulations (Northern Ireland) 2005 as follows:

- FTC Ref: FTC000260 with respect to Regulation 13 (1)
- FTC Ref: FTC000261 with respect to Regulation 18 (1) and (2)

Compliance with these notices is to be achieved by 21 October 2026. A follow up inspection will be undertaken to determine if compliance has been achieved.

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

	Regulations	Standards
Total number of Areas for Improvement	4	3

Areas for improvement and details of the QIP were discussed with Ms Delma McCurry, Registered Manager, as part of the inspection process and can be found in the main body of the report. The timescales for completion commence 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 25(1) (2) **Stated:** First time **To be completed by:** With immediate effect	The responsible individual should devise and implement a robust programme of maintenance for the theatre suite during lengthy periods of non-use and ensure a record is made evidencing the implementation of the programme. Ref: 5.2.1
	Response by registered person detailing the actions taken: A programme of maintenance has been developed to include cleaning schedules,water flushes and water temperature records and maintenance and servicing of equipment and the ventilation system.

Area for improvement 2 **Ref:** Regulation 15 (6) **Stated:** First time **To be completed by:** With immediate effect	The responsible individual shall ensure that controlled drugs are administered in accordance with controlled drug legislation, Summary of Product Characteristics, product licence, professional standards and published guidance. Ref: 5.2.3
	Response by registered person detailing the actions taken: All persons involved in the administration of CD's are administering in accordance with Controlled drug legislation.
Area for improvement 3 **Ref:** Regulation 15 (6) **Stated:** First time **To be completed by:** With immediate effect	The responsible individual shall ensure a hospital formulary specific to Jace Medical, including minimum stock levels, is developed to ensure adequate supplies of all required medicines, including controlled drugs, are available on all occasions. Ref: 5.2.3
	Response by registered person detailing the actions taken: A hospital formulatory has been developed that is specific to Jace Private hospital.
Area for improvement 4 **Ref:** Regulation 22 **Stated:** First time **To be completed by:** 30 September 2026	The responsible individual shall establish a clear protocol to enable staff to escalate any matter of concern for the attention of the responsible individual and/or the registered manager in a timely manner. Records should be retained in this regard. Ref: 5.2.4
	Response by registered person detailing the actions taken: The lead nurse will escalate any matters for concern in a timely manner.All debrief records following all procedure lists will be reviewed by the lead nurse and registered manager and actioned when necessary.Records will be retained of any discussions and actions regarding this.
Action required to ensure compliance with the Minimum Care Standards for Independent Healthcare Establishments (July 2014)	
Area for improvement 1 **Ref:** Standard 25 **Stated:** Second time **To be completed by:** 31 October 2026	The responsible individual shall ensure individual staff receive training and competency assessment on medicines management as part of their induction, and refresher training in accordance with the hospital's mandatory training programme. Ref: 5.2 & 5.2.3
	Response by registered person detailing the actions taken: A medicine management module is now available to all relevant staff .All active nursing staff have completed this online training.

Area for improvement 2 **Ref:** Standard 26 **Stated:** Second time **To be completed by:** With immediate effect	The responsible individual shall ensure that the temperature of the medicine refrigerator and storage areas are monitored daily to ensure that medicines are stored at the manufacturer's recommended temperature. Ref: 5.2 & 5.2.3
	Response by registered person detailing the actions taken: The medicine refrigerator temperature is checked daily and recorded.A room thermometer is now in place to monitor the temperature of the room the medicine refrigerator is in on a daily basis.
Area for improvement 3 **Ref:** Standard 27 **Stated:** First time **To be completed by:** 31 October 2026	The responsible individual shall review and update the Standard Operating Procedures for the management of controlled drugs to ensure they include procedures for prescribing and administration. Ref: 5.2.3
	Response by registered person detailing the actions taken: This has been reviewed and 2 additional sections have been added.One section for procedures for administration and 1 section for prescribing

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





The **Regulation** and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews