Ultralase Eye Clinics Limited - Liverpool

Quality Report

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Date of inspection visit: 7 and 8 September 2017
Date of publication: 07/12/2017

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

Ultralase Eye Clinics Limited Liverpool is operated by Ultralase Eye Clinics Limited. The service is for day cases only. Facilities include a theatre for the treatment of refractive eye conditions and rooms and equipment for assessment for suitability for surgery.

The service provides refractive eye treatment for adults and we inspected this service. There were 1341 treatments carried out in the period January 2016 to December 2016.The service did not treat children and young people.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 7 September 2017 along with an unannounced inspection on 8 September 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We regulate refractive eye surgery but we do not currently have a legal duty to rate them when they are provided as a single specialty service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- The clinic had robust processes in place to manage patient risk and to provide safe treatment for patients.
- There had been no healthcare acquired infections at the clinic and theatres and clinics were visibly clean and tidy. There was an infection control policy andinfection control processes were audited.
- We saw that the pre-assessment of patients to determine suitability for treatment was robust and that there were detailed discussions about the risks, benefits and side effects of all treatments.
- There were robust consent processes in place for each type of treatment and patients had to sign at each stage of the process to show that they had read and understand each statement.

Summary of findings

- The clinic worked to guidance from the National Institute of Clinical and Health Excellence and the Royal College of Opthalmologists.
- Staff were caring and there was positive patient feedback from surveys.
- Staff said it was a good place to work and that they were supported by their manager.

However:

- There was no information availalble in large print.

Ellen Armistead.

Deputy Chief Inspector of Hospitals (acute)

Summary of findings

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Summary of this inspection

Background to Ultralase Eye Clinics Limited - Liverpool

Ultralase Eye Clinics Limited - Liverpool is operated by Ultralase Eye Clinics Limited. The service opened in 1991. It is a private hospital in Liverpool, Merseyside. The hospital mainly serves the communities of Merseyside. It also accepts patient referrals from outside this area.

Our inspection team

The team that inspected the service comprised a CQC lead inspector. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection.

Why we carried out this inspection

We carried out this inspection as part of our comprehensive inspection programme for independent hospitals.

How we carried out this inspection

During the inspection, we visited the hospital. We spoke with seven staff including three registered nurses, two patient administrators, one consultant, one optometrist and the clinic manager. We spoke with three patients and one relative. We reviewed five sets of patient records.

Information about Ultralase Eye Clinics Limited - Liverpool

Ultralase Eye Clinics Limited Liverpool is operated by Ultralase Eye Clinics Limited .The service opened in 1991. It is a private hospital in Liverpool, Merseyside. The hospital mainly serves the communities of Merseyside. It also accepts patient referrals from outside this area.

The hospital has had the registered manager in post since 29 January 2014. The date of the last inspection was 25 April 2014 and there were no compliance actions arising from this inspection. The regulated activities for the location are:

- Diagnostic and screening
- Surgical procedures
- Treatment of disease, disorder or injury.

The hospital provides refractive eye services to fee paying patients, it does not have any NHS patients. In 2016 the hospital undertook 243 laser treatments and 1098 lens procedures (January 2016 to December 2016).

The hospital treats adult patients over 21 years of age, patients under 21 are only treated if they meet certain criteria.

Summary of this inspection

During the inspection, we visited the hospital. We spoke with seven staff including three registered nurses, two patient administrators, one consultant, one optomotrist and the clinic manager. We spoke with three patients and one relative. We reviewed five sets of patient records.

Three surgeons worked at the hospital under practising privileges. There were three registered nurses and two patient advisors who were employed by the hospital. There were three optomotrists who worked on a zero hours contract. The hospital also used bank nurses.

Track record on safety

- No never events and no serious injuries
- Clinical incidents : three no harm and two low harm.
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- Four complaints

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Laser protection service
- Maintenance of medical equipment

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently have a legal duty to rate refractive eye surgery, where these services are provided as an independent healthcare single speciality service.

We found the following areas of good practice:

- The hospital recorded incidents and there was feedback to staff through staff meetings and emails.
- Infection control processes were in place and these were audited.
- Staff had completed their mandatory training.
- The hospital had systems in place to reduce the risk to patients.
- Equipment was serviced appropriately.
- Processes were in place to protect staff and patients in the use of cytotoxic medicines.

However:

- The clinic did not have a policy for the duty of candour.

Are services effective?

We found the following areas of good practice:

- The clinic used guidance from the National Institute of Health and Care Excellence and the Royal College of Opthalmologists.
- Patients were offered pain relief when appropriate.
- The clinic team worked well together and there was appropriate training and completion of competencies.
- The surgeons had received appropriate training and continuing professional development to deliver the service.

  Consent processes were robust and patients had to sign to say that they had read and understood every part of the process.

Are services caring?

We found the following areas of good practice:

- The clinic did patient satisfaction surveys at each post-operative appointment. Feedback was mainly positive.
- Staff explained to patients about treatment before they proceeded.
- We saw that staff were kind to patients and made them feel relaxed before their treatment.

Summary of this inspection

Are services responsive?

We found the following areas of good practice:

- There was efficient access and flow through surgery with patients booked in small numbers to reduce waiting times.
- Complaints were answered in a timely manner according to the organisational policy.
- The hospital opened every day except Sunday from 8am to 6pm giving patients a choice of when they wished to attend the clinic.
- Patients were given appropriate information so they could make a decision about treatment.

However:

- There was no patient information available in large print.

Are services well-led?

We found the following areas of good practice:

- There was a vision and strategy for the organisation that included the importance of staff and a focus on patients.
- We saw that the surgeons had indemnity insurance and all the appropriate documentation had been completed for practising privileges.
- There were regular updates for all staff who worked in the organisation in the form of meetings and conference calls.
- Leadership was strong and staff said that it was a good place to work and that they were supported by their manager.

Refractive eye surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are refractive eye surgery safe?

Incidents and safety monitoring

- The clinic had not recorded any never events in the reporting period from June 2016 to June 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.
- There was an electronic form for the reporting of incidents and we saw that staff reported incidents. In the period January 2017 to June 2017, there were 11 incidents reported. Five of these were clinical incidents. Two of the clinical incidents were about lenses which were faulty or had been dropped in theatre. Following these incidents the clinic ordered two sets of lenses for every patient. We saw that there was a thorough investigation process for incidents.
- There was feedback to staff through the monthly staff meetings but the manager said that if anything urgent needed to be communicated this could be done by email, with a read receipt, to check that staff had read the email.
- The clinic manager would email the incident reports to corporate services every six months, staff in corporate services had an overview of trends of incidents and could report back to the clinics through the monthly telephone conference calls for all the clinic managers.
- The clinic did not have a duty of candour policy . We did not see any examples of incidents where the duty of candour would have applied. The manager said that that the staff in the clinic would always apologise to patients if something went wrong. Staff told us that that they would say sorry to patients.

Mandatory training

- Mandatory training was either on line or at the corporate training venue of the provider.
- We saw documentation showing that all the staff at the clinic had completed their mandatory training. This included data protection, health and safety, equality and diversity, infection control, medicines, safe guarding for children and young people and vulnerable adults and intermediate life support (ILS)for the nurses. Two of the nurses told us that they had just completed their ILS training at a nearby hospital trust. They said that this had been useful as the trainer had made the training relevant to their service.

Safeguarding

- The clinic had a child protection policy which followed the National Intercollegiate Guidelines for Safeguarding. The manager said that staff would raise any safeguarding concerns with them and staff said that they were aware of the processes for safeguarding.
- All staff were trained to level two for safeguarding for children and young people and the manager was trained to level three.
- All staff were trained in the safeguarding of vulnerable adults.

Cleanliness, infection control and hygiene

- There had been no reported health care acquired infections at the clinic in the last 12 months. The clinic and the clinical areas were visibly clean and tidy. There were hand washing sinks in all the treatment rooms and hand gel was available around the clinic.

We saw that staff washed their hands and used personal protective equipment appropriately. Nurses washed their hands every time they put drops in a patient's eyes.

- There was an infection control policy which was in date and infection control was part of the staff induction programme and the mandatory training programme. The induction programme included good hand washing techniques.
- There was a cleaning policy for theatre areas; there was a daily clean at the beginning and at the end of the day and a more comprehensive weekly clean. We saw that the cleaning schedules had been completed and dated and signed for daily and weekly cleans were signed and dated. The treatment rooms were deep cleaned every six months or following any maintenance by an external company .The deep cleaning was carried out by outside contractors and we saw that this had been completed in May 2017.
- Patient areas and treatment rooms outside the theatre areas were cleaned by outside contractors. We saw that the clinic was exceptionally clean and tidy.
- There was an unannounced infection control audit carried out by the provider on 11 May 2017. The clinic scored 10 out of 11 on the hand hygiene audit, 10 out of 10 on the personal protective equipment and nine out of nine for clinical practices.
- Patients were asked if they have had MRSA in the past six months or if they had direct contact with someone suffering from MRSA during this time. If the answer was yes, then the patient was requested to have a nasal swab done by their GP to confirm they were not carrying the bacteria. Ultralase would meet the cost of this test if required. Treatment would not take place until a negative test result was available.
- We saw that there were different coloured containers and bags for different types of waste. Containers were fastened to the walls and containers used to dispose of cytotoxic waste were not used to dispose of any other items. Sharps bins were not overfilled and were dated. Clinical waste was collected weekly.

Environment and equipment

- The lasers in the clinic were only accessible through a door with a key pad so the public were unable to enter this area without a member of staff. All the rooms with lasers in them had a light that came on outside the room to indicate when the laser was in use. Appropriate goggles were available for the different lasers.
- The laser protection advisor performed a detailed risk assessment of the laser controlled area at the clinic every three years or when any changes to equipment or the environment occurred. This was last completed in November 2015. There was an action plan in the assessment for the manager to address and confirm when all necessary actions had been completed. We saw that there was a risk assessment for each laser in the clinic. There was also an optical radiation policy.
- The parameters of one of the lasers were checked every day and the results were entered onto a computer. The other laser was checked on the days of treatment, these checks were recorded and could be adjusted if appropriate.
- The clinic had a laser protection supervisor who was the clinic manager, who was present on a treatment day. If the manager was unavailable another appropriate member of staff would attend from another clinic.
- The theatre was a minimal access intervention operating theatre. Laser refractive eye surgery should be carried out in this environment in line with the guidance from the Professional Standards for Refractive Surgery (2017).
- There was a resuscitation box in the pre-theatre assessment room, there was also a defibrillator and the box contained adrenalin to be used in the event of anaphylaxis. We saw that the label on the box had all the expiry dates for any equipment or medicines in the box, we also saw that the box was checked daily and that this was recorded.
- We saw evidence that the theatre had been serviced on the 30 May 2017 and that air filters were changed as appropriate.
- We saw records that indicated that the temperature and humidity of the theatre was checked daily. If the temperature rose above 25 degrees then an engineer was called to adjust the air conditioning.

- The clinic mainly used single use instruments for surgery and there was a policy for single use instrumentation. Some of the lens surgery required non –single use instruments. These instruments were cleaned, following surgery and then sent to a NHS hospital trust for sterilisation. This was done weekly and sterilised instruments were returned to the clinic as the dirty ones were collected. The manager said that this worked well and there had been no problems with the arrangement. All the instruments were stored in locked cupboards in a room next to the theatre.
- There was monitoring equipment in theatre to monitor patients during treatment, this measured blood pressure and oxygen saturation, we saw that this equipment had been serviced and maintained.
- The clinic had their own maintenance engineer who worked at the company clinics around the country; they attended the clinic every week to maintain and service equipment and would come more often if necessary.

Medicines

- There was a medicines policy for the organisation. Medicines were ordered by the nurses every month according to the planned activity at the clinic. Medicines that were out of date or due to go out of date before the next surgery session were disposed of according to the medicines policy. The batch number and expiry date were recorded on a sheet and the method of disposal was noted. We saw that these sheets had been completed.
- There was a medicines transfer sheet if medicines were transferred to another clinic, the batch number and expiry date was noted on the sheet.
- We checked the medicine cupboards and all the medicines were in date. The temperature of the room was maintained at 25 degrees and if it went above this the clinic would refer to the supplier of the medicines for advice.
- There were two medicines fridges which were checked daily and the maximum and minimum temperature levels were recorded, these were in the appropriate range for storage. Fridges were cleaned every week.
- The surgeons were responsible for the prescribing of medicines to patients following. treatment. We saw that these were handed to the patient in the recovery room and the surgeons gave patients instructions on their use and frequency. Patients eye drops from the patients' take-home supply were used during treatment to prevent cross-contamination. The patient was be advised that the seal has been broken, and told that they were safe to use.
- A member of the clinic staff explained the medicines to the patient and their carer to ensure that they understood the instructions printed on them. They then recorded this on the patient medication records sheet, signed and dated it and entered this into the patient's electronic record. A paper copy of the prescription, signed by the surgeon was retained by the clinic.
- Surgeons prescribed appropriate medicines that a patient may require at their follow up appointment with the optometrist. If the patient needed them they were given to the patient at the follow up appointment. Optometrists can provide some medicines provided it is in the course of their professional practice.
- The clinic used cytotoxic medicines as part of some laser procedures to reduce side –effects They used Mitomycin C which is a cytotoxic medicines which is used as part of some laser procedures to reduce side –effects. Staff made patients aware of the use of these medicines and there was a separate consent form for the use of the medicine.
- There was a policy and procedure for the use of cytotoxic medicines. This included a procedure for minimising exposure to cytotoxic medicines, a procedure for managing spillage of cytotoxic medicines, a procedure for disposal of cytotoxic medicines, a procedure for management of accidental personal contamination with or exposure to a cytotoxic preparation and a protocol for use of Mitomycin C by medical practitioners.
- If a patient required the use of the medicine, it was delivered to the clinic on the day of the procedure. The medicine was pre-prepared and stored in a fridge at between 2-8 degrees centigrade in a clearly labelled container. Administration of the medicine was undertaken inside the theatre by staff who had been trained in the in the safe handling and administration

of cytotoxic drugs and who had been assessed as competent to administer cytotoxic agents, this included training for the recognition and treatment of anaphylaxis. Following treatment the medicine was disposed of in the appropriate cytotoxic waste receptacles.

- Mitomycin C and other cytotoxic medicines were never transferred between clinic sites.

Records

- Patients' records were electronic, with the exception of the signed paper consent forms. Authorised staff had access to a patients electronic notes from any clinic if required. The company had a bespoke computer system in place, which allowed full network access for authorised staff irrespective of where the records were entered or the location the treatment took place.
- Following surgery additional paperwork and forms were uploaded onto the patients' file which could be accessed in the uploaded section of the patients' medical file in any clinic location.
- We saw that every patient contact was recorded in the patient record and that telephone calls were recorded.
- There was a laser log in theatre which contained patient details, the procedure undertaken, the type of anaesthetic used and the lens used and the label from the lens packaging. This was completed following each patient treatment.
- We saw that the surgeon completed their records as each patient left the theatre.
- Following surgery all patients were given a letter detailing the procedure that had been undertaken and the medicines that had been prescribed post-operatively to take to their GP. Permission was sought at consultation stage from the patient, so that the clinic could contact the patients GP if necessary.

Assessing and responding to patient risk

- There was an extensive pre-treatment assessment form that patients completed on their first visit to the clinic. There were a number of medical conditions and medicines that would make the patient unsuitable for treatment. Following this they would have topography and other tests on their eyes before seeing the optometrist. Topography is a non-invasive medical imaging technique to map the surface curvature of the cornea of the eye.
- The patient would then see the optometrist who looked at the patient's medical assessment form. They would undertake more tests on the patient's eyes and if the patient was appropriate they would make recommendations about the suitability of treatment and a recommendation of appropriate treatment. They would also advise them about the risks and benefits of various treatments.
- Patients were provided with written information about their treatment. If the patient was unsuitable for treatment due to a medical condition or if their eyes were not suitable for the treatment they wanted the patients were refunded the initial fee charged by the clinic. There were some conditions where the surgeon would make the final decision about treatment.
- Following this assessment the patient would meet with the surgeon to discuss their treatment options and the surgeon would make the final decision about their treatment. Patients could ask for a second opinion if they wished to and they could withdraw from the process at any stage.
- If patients decided to go ahead with treatment they had a medical review and if patients met the criteria for treatment were booked for surgery. There was a cooling off period of between seven to 14 days depending on the procedure. This was in line with the Royal College of Ophthalmology guidelines Professional Standards for Refractive Surgery 2017. At any time during the process patients could telephone the clinic to speak with the surgeon or to request further information.
- All patients had their blood pressure taken at the pre-assessment clinic. This information helped to inform the optometrist of the suitability of the patient for any treatment. We observed that a patient who attended the clinic who was told that they were unsuitable for treatment had raised blood pressure. The optometrist asked if they could contact the patient's GP by letter and suggested that the patient attend the GP surgery.

Refractive eye surgery

- Patients were asked about any allergies at their pre-treatment assessment; these were recorded onto the patient record. Allergies were checked at every point in the pathway. The pre-operative nurse asked about allergies and this was checked again as the patient went into theatre. If the patient had allergies this was recorded on the white board in theatre.
- If the optometrist or the surgeon had any issues about a patients suitability for treatment they would write to the patients GP. An example was given where a patient with a mental health condition appeared suitable for treatment but following advice from the GP the treatment did not go ahead.
- Patients had a consultation with the surgeon on the day of surgery to check their medical history and their consent for the procedure. The eye for treatment was marked at this stage. The surgeon checked with the patient the planned refractive outcome, the lens model and power and the lens implant to be used.
- The clinic used the World Health Organisation surgical safety checklist for eye surgery during each procedure. Patients went into the pre- surgical assessment room and we saw for a patient having lens surgery that the World Health Organisation checklist was completed. The nurse checked the patient's details, the surgical site, the procedure, any allergies and the lenses for surgery.
- There was a staff huddle before surgery started, the surgeon asked about the patients on the list, if there were any problems or any allergies and staff identified their role in the surgical pathway.
- Prior to surgery the theatre nurse rechecked all of the patient's details. For patients returning to theatre for the second eye the nurse asked if anything had changed since their last appointment, before they went to the theatre. The patient's details were written on a white board in theatre including the lens details.
- Patients had their blood pressure and their oxygen saturation monitored during surgery.
- The clinic always supplied two sets of lenses for patients. There had been incidents where a lens had been dropped in theatre or had been damaged when it was removed from the packaging.
- Laser patients usually had both eyes treated at the same time, though lens patients were treated a week apart. If a surgeon wanted to treat both eyes for a lens patient on the same day they had to have permission from the medical director. There was a policy for bi-lateral surgery and both eyes were treated completely separately.
- Following surgery patients were taken into a recovery room adjacent to the theatre. This had a reclining chair and the patients' blood pressure was checked, they were also offered refreshments and biscuits. The patient had a call bell. There was not always a nurse in the recovery area; sometimes it was one of the patient advisors.
- Following surgery patients were supplied with a number of medicines depending on their treatment, these included antibiotic eye drops to reduce the risk of infection, steroid eye drops to reduce the risk of inflammation and a diuretic to reduce intra-ocular pressure.
- All patients were supplied with an emergency card for their surgeon, so that they could contact them directly overnight in case of any queries or concerns. Patients were made aware that during clinic opening times they could call the clinic directly for advice, this was given over the phone or arrangements were made for the patient to return to the clinic for a review with either the optometrist or treating surgeon.
- There was always an optometrist available on the day of surgery as some laser patients needed to be seen immediately following treatment. Some patients were seen on the day following treatment for post–operative check-ups though some types of laser treatments were only seen three to five days following treatment. There were standard operating procedures for all types of treatment which included all follow up procedures.
- The clinic was located very close to an NHS trust; the staff said that they would ring 999 in case of any emergency. There were resuscitation drills at the clinic every three months.
- The clinic had an agreement with a nearby hospital trust and patients could be referred there in certain circumstances including post-operative infection. Lens

patients were given an implant card in case they had to attend an urgent and emergency care centre to inform staff what lenses had been implanted into their eyes.

Nursing and medical staffing

- There were three ophthalmologists who had practising privileges at the clinic. These surgeons had the appropriate qualifications for their roles according to guidance from the Royal College of Ophthalmology
- There were three optometrists who worked at the clinic, they had zero hours contracts.
- The clinic had just employed a nurse, making three in total. They worked flexibly to meet the needs of the service. The clinic also used bank nurses; they had all worked at the clinic before and were experienced in the surgical procedures.
- There were two patient advisors, they did the topography testing on the patients and could support the surgeons in theatre. One of the them was the lens advisor and was responsible for ordering lenses following the patient's consultation with the surgeon. The other patient advisor was a trainer for the organisation and worked on customer service and issues such as patient literature.

Major incident awareness and training

- The clinic had a major incident policy that was in date.
- The clinic had backup generators in case of a power failure. These would last for 10 to 15 minutes giving surgeons the opportunity to complete treatment.
- There was an uninterruptible power supply to supply an emergency power supply if necessary. There was a policy for laser failure.
- Fire escapes were well marked and there was emergency lighting if necessary. Fire alarms were checked weekly and serviced every six months.

Are refractive eye surgery effective?
(for example, treatment is effective)

Evidence-based care and treatment

- Ultralase had a medical advisory board which set standards for all surgeons and optometrists across the company to work to. Standards were set according to the National Institute of Health and Care (NICE) guidelines and recommendations from the Royal College of Ophthalmologists as well as guidelines by other relevant regulatory bodies.
- NICE guidance was circulated nationally through the medical advisory board. We saw that the minutes of the meeting on 13 May 2016 that there had been discussion about the Royal College of Ophthalmology guidelines - Professional Standards for Refractive Surgery 2017.
- Policies at the clinic were based on NICE guidance and guidance from the Royal College of Ophthalmologists.

Pain relief

- One of the laser treatments available was more likely to cause pain following treatment and we saw that patients were advised about this at the pre-treatment appointment. The information booklets and the consent forms advised patients them about pain following surgery.
- We saw that nursing staff asked patients following surgery if they had any pain, patients could then be offered analgesia as appropriate.

Patient outcomes

- The surgeons had their outcomes audited by the company. The audits contained the numbers of treatments carried out, a comparison of the outcomes and the patient satisfaction. The most common adverse event for cataract surgery is posterior capsular rupture. (UK national acceptance rate 2%), the surgeon had no posterior capsule ruptures in the period January 2016 to December 2016; they also had no never events and no complaints and no incidences of endophthalmitis. (Endophthalmitis is an inflammation of the interior of the eye and is a possible complication of all intraocular surgeries, particularly cataract surgery; it can lead to loss of vision and the eye.) The surgeon had treated 402 patients in this period.

- The other surgeon who did the laser surgery had better refractive outcomes for 472 eyes than the England average guidelines from the Royal College of Ophthalmologists.
- Patients who experienced cloudiness in the lens following cataract surgery (post capsular opacification) were offered laser treatment to try to correct this. There was an additional charge for this.

Competent staff

- We saw from records that surgeons had the Royal College of Ophthalmology Certificate in Laser Eye Surgery as appropriate. The surgeon who performed the laser surgery had undertaken the minimum 50 hours of continuing professional development and had conducted a patient feedback exercise that included a patients' experience from their refractive surgery practice. This is in line with the Professional Standards for Refractive Surgery from the Royal College of Ophthalmologists.
- The laser protection supervisor attended a bespoke certified training course to enable them to act as laser protection supervisor. This was renewed every two years. All attendees completed a test at the end of the course.
- All the staff at the clinic had attended the core of knowledge and laser protection training. This was every two years and was carried out at the corporate external training venue. This was followed by assessment and sign off for competency before working unsupervised.
- All staff were required to read the local laser rules and the risk assessment, they had to sign an affirmation prior to working in the laser controlled area. We saw that staff at the clinic had signed the affirmation.
- We spoke with an optometrist who said that when they started at the clinic they shadowed the head optometrist in another clinic for three days. Following this an optometrist sat in with the optometrist for three days at the Liverpool clinic. They were given an hour for consultations and a reduced diary for two months. They said that if there were any problem or they needed advice that they could email the head optometrist who was responsive and good at getting back to them.
- The optometrist said that they could attend doctors' meetings and optometrists' meetings and that there were opportunities for continuing professional development and good professional support from the organisation.
- There were corporate training days for the optometrists, the nurses and the managers; these were usually held every six months.
- All the nurses had received training in intermediate life support skills.
- The nursing staff had received training in the administration of cytotoxic medicines.
- Staff had annual appraisals and regular one to one meetings with the manager.
- One of the patient advisors was responsible for the ordering of lenses for the patients. They had training at the London clinic and then supervised training at Liverpool before they were signed off as competent. The advisor worked closely with the consultant to manage the different types of lenses and to order the correct lenses for patients' treatment.
- We saw from staff records that the nurses had completed their revalidation for the Nursing and Midwifery Council.

Multidisciplinary working

- We saw that staff worked well together in the clinic; there was a team ethos that was about providing good care to patients.
- The optometrist said that the lead optometrist for the organisation was always available if necessary and responded quickly to queries and requests for advice.
- Staff, including the optometrists, said that the consultants were approachable and were happy to respond to questions.

Access to information

- Computers were available around the clinic and staff could access company policies, relevant guidance and the electronic patient record.
- The electronic medical records of patients were available at all clinics to staff with appropriate authorisation.

- Patients were given a record of their treatment to take to their GP following treatment. This included the procedure that was undertaken and the medicines given following treatment.

Consent and Mental Capacity Act

- Consent processes were robust at the clinic. When patients came for their assessment they were given a consent form to take away with them. There were different consent forms for different procedures.
- The forms gave advice to patients about the alternatives to the treatment that they were considering and the risks, benefits and possible side effects of each treatment. The form also outlined the likelihood of these side effects both short and long term.
- The forms contained information that some professions including the armed forces and the police would not accept patients who had undergone laser surgery. Information was also available for patients who participated in contact sports as certain treatments were not recommended for these patients.
- The consent forms included information on the use of Mitomycin C for certain patients and the risks of bi-lateral treatment for laser patients. The form informed the patients about medicines that would have to use following treatment and aftercare, including the frequency of visits following treatment. There was a separate consent form for the use of Mitomycin C
- Patients took these forms away with them and brought them to their consultation with the surgeon. At this appointment the surgeon discussed the patient's choice of treatment following recommendations from the optometrist and any medical or social issues that could prevent the patient from proceeding with treatment. The surgeon's decision was final. If the patient agreed to treatment they went through the consent form, each step of the pathway was numbered and the patient had to sign at each stage to say that they understood and agreed with each of the statements.
- Following this the patient had a cooling off period, which was usually a week for laser patients and 10 days for lens patients before their treatment.
- When the patient arrived at the clinic on the day of surgery, they met with their consultant to go through the procedure and the consent forms. The patient and the surgeon signed the forms and this was documented in the patient record.
- The clinic would not treat any patient who could not consent to treatment.

Are refractive eye surgery caring?

Compassionate care

- During the pre-treatment processes we saw that staff explained to patients what was going to happen to them, this included the administration of eye drops to dilate the pupils to make it easier to examine the eye. They told patients that they might experience some discomfort and asked patients to tell them if they experienced any discomfort from the tests and the eye drops.
- In the pre-treatment room we saw that the nurse explained to the patients what the drops were for and what they did each time they put drops in their eyes
- When patients attended the clinic following treatment they were asked to complete an after-care questionnaire. This was available on a touchscreen unit in reception. The questions were how would you describe the results of treatment, will you be recommending the company to your friends and family and overall, did you feel you were treated with respect and dignity while you were in the clinic. If the patient answered no to three specific questions the clinic manager who try to resolve any problems or issues that the patients had with the service.
- The results of the aftercare survey for the Liverpool clinic were the period 1 Jan 2016 to 31 December 2016. The survey included 130 patients, 59.5% thought that the service was excellent, 37% thought it was good, 2.5% thought it could have been better and 0.3% said that it was not worthwhile
- There were a number of cards and letters on display around the clinic that had been sent in by patients. They were very positive and some described how the clinic had given them their sight back.

Refractive eye surgery

Understanding and involvement of patients and those close to them

- We observed a consultation between the optometrist and a potential patient. They were told the relevant treatment options and the risks and benefits of these options. The optometrist made clear the immediate side effects of the treatment including any pain that might occur following treatment and other consequences of treatment in the medium and long term. This consultation was very detailed. We spoke with the patient following the consultation and they said that they were surprised at how thorough and honest the consultation had been.
- We spoke with another patient who had come for an initial consultation; they were informed that their prescription was unsuitable for treatment. They said that the consultation was good and although they couldn't have treatment they understood the reason why.
- The clinic would put potential clients in touch with another patient who had undergone treatment at the clinic with the consent of the patient.
- Patients were asked to bring somebody with them on the day of treatment and for the pre-operative assessment; this was because patients weren't allowed to drive after they had drops in their eyes that dilated their pupils.

Emotional support

- We saw that staff had a good rapport with the patients; they built up a relationship from the initial consultation to the treatment and follow up of the procedures. Staff greeted patients by name on arrival at the clinic and made then feel welcome. We saw that staff reassured patients and relaxed them; this was in the pre –treatment assessment and before and during surgery.
- Following treatment patients were asked how they felt and if they have any discomfort. They could spend as long as they wanted in the recovery room before going back to the reception area.
- We saw feedback from a patient who said that the staff relaxed them before surgery and helped them through the procedure.

Are refractive eye surgery responsive to people's needs?

(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- The clinic was open Monday to Saturday 8am to 6pm. The clinic could open on Sundays if there was a demand. It was located in the city centre, there was nearby car parking and there were good public transport links. Some patients travelled quite a distance for treatment at the clinic.
- The clinic had undertaken 243 laser treatments in the last year and 1098 lens procedures. (January 2016 to December 2016)
- The clinic was spacious and light and airy. There were comfortable seating areas for patients and tables with magazines. There were three assessment rooms, two topography rooms and two rooms where patients could chat with a personal advisor. All the rooms could accommodate a patient and a relative or carer.
- In the theatre area there was a pre–assessment room which also housed one of the lasers, the patient preparation room, the theatre which was used for laser and refractive lens surgery and a patient recovery room with a reclining chair and a call bell.
- Free refreshments were available in the waiting areas of the clinic and patients were offered a drink and a biscuit following their procedure.

Access and flow

- We saw that access and flow through the service was efficient. Patients could book initial appointments through the website or through the corporate telephone line. Patients were seen promptly at their convenience. If patients were accepted for surgery, they were given surgery dates following the cooling off period. Different days were available though lens surgery was usually carried out on a Friday so that patients could recover over the weekend.
- On the day of surgery , patients were asked to come into the clinic for surgery in batches. Patients were not kept waiting long and were moved through the

pre-operative assessment room into theatre and then into recovery. Follow up appointments could be booked at alternative clinics at the patients convenience.

- There were low levels of cancellations and returns to theatre. There had been 15 cancellations of refractive eye procedures in the last 12 months. None of these had been on the day of surgery. There were 12 returns to theatre for repositioning of the lens following treatment, none of these was urgent.
- There were 31 retreatments following lens treatment and 16 enhancements following laser treatment in the last 12 months, none of which were urgent.

Meeting people's individual needs

- There was access for those with mobility issues through automatic doors at the front of the building. The clinic was all on one floor providing access to the whole of the clinic. There was a toilet for people with mobility issues,
- There was a hearing loop at reception for people with hearing loss or impairment.
- Translation services were available; the manager said that they had been used once. The interpreter was available at consultations of the patient and then in the pre-operative room before the patient went into theatre to check consent to the procedure.
- There was no easy read information available in the clinic and we did not know if the service used plain English guidelines for their literature. We did not see if literature was available in larger print.

Learning from complaints and concerns

- There was a complaints policy and patients could make a complaint verbally or in writing. Verbal complaints were logged by the staff in the patient record. If the complaint needed to go to head office it needed to be in writing.
- Staff would try to resolve the complaint locally and it was the responsibility of the manager to oversee the complaint.
- Once a written complaint was received the clinic manager or head office would acknowledge the letter within two days and respond in full within 20 days. If there was a delay in the process then a holding letter was sent to the complainant to inform them of the delay
- There have been four complaints to the service in the last 12 months. The complaints were about treatment outcomes which had been highlighted in the pre-assessment process. We saw that the hospital apologised to the patient as part of the complaints process.
- We saw that the clinic had responded to complaints in the specified time frame. The policy contained information about how to complain to the regulators of the service.
- There have been no complaints to the Care Quality Commission in the past 12 months.

Are refractive eye surgery well-led?

Leadership and culture of service

- Leadership was robust in the clinic. The manager worked with the staff and there was an open culture of working so that patients who had treatment were fully informed and understood the risks and benefits of any treatment option.
- There was a culture of continuous improvement and the organisation wanted to be good employers to their staff. Staff said that they felt supported and valued.
- Staff were complimentary about the organisation and said that training was thorough and that they were a good organisation to work for.
- Staff we spoke with said that they enjoyed working at the clinic and they felt that they were part of a team.
- Patients received a statement that included the terms and conditions of the service being provided and the full costs of the treatment and any guarantees that came with the treatment.

Vision and strategy

- The clinic hadcorporate aims and objectives, these included the provision of safe services by registered, trained healthcare professionals.

- The clinic hadcorporate vision and values. These were about investing in its services, being a good employer and recognising staff as its most valuable assets, having staff that were trained and well managed and to have a customer focus.
- Staff were aware of the vision and values and considered that they played a part in the vision and values of the organisation. They said that their training was robust and they were proud of their work.

Governance, risk management and quality measurement

- The management structure at the clinic included the registered manager who managed the clinic supervisor. The clinic supervisor managed the clinic team and the patient advisors.
- We looked at the staff records for two of the surgeons who worked at the clinic. We saw that the practising privileges documentation had been signed and dated by both surgeons. This was updated every year. We also saw that both consultants had indemnity insurance and that their appraisals were in date. There were references from previous employers and identification checks and documentation from the disclosure and barring service. We also saw that vaccination records were up to date.
- Surgeons who worked in the NHS had copies of their NHS appraisal in their folder. If the surgeons did not work for the NHS there was a company appraiser who was the previous medical director for the organisation.
- There was a risk register for the clinic with risks rated and with mitigating actions. These included dealing with emergency medical situations and staffing levels.
- There were governance meetings across the organisation. These included surgeons meetings which were held every three to four months, optometrists attended these meetings, the medical advisory board met every three to four months and was attended by medical directors and some invited surgeons. There were nurse's conference calls every two months and managers calls every month.
- The clinic held a monthly staff meeting for all staff. Agenda items included complaints, incidents and any relevant issues raised at the manager's call and the nurse's call.
- There was a good policy framework in place to support the activities of the organisation.

Public and staff engagement

- Patients were encouraged to complete a survey every time that they attended the clinic and feedback was used to improve the service.
- Staff were engaged and said that they felt supported by the company.
- As part of mandatory training there were modules on managing personal stress and personal safety.

Innovation improvement and sustainability

- There had been a significant investment in equipment at the clinic to produce the best outcomes for patients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

The provider should provide patient information in large print.