Optegra London

Quality Report

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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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Optegra London is an eye hospital located in North London. It is part of a nationwide company, Optegra UK Limited, which has seven hospitals and three outpatient clinics in the UK. The hospital provides services to adults over 18 only.

The hospital was opened in 2012 within a purpose-built day case facility. The hospital is set over two-floors and has three consulting rooms, a reception area, four diagnostic rooms, two operating theatres, a treatment room and pre and post-operative areas.

Services provided include refractive eye surgery, ocular plastic, retinal diagnostic, general surgical services and ophthalmic disease management. During the 12 months prior to our inspection, the hospital recorded 1,156 surgical procedures. Of these 70% were for cataract surgery, 12% laser, 11% refractive lens exchange and small number (approx. 7%) of other procedures including age related macular degeneration (AMD) injections, vitrectomy and eyelid surgery for non-cosmetic reasons.

During the 12 months prior to our inspection the hospital recorded 2,406 outpatients appointments with the majority of these patients (66%) seen for follow-up after surgery. Others were seen for an initial consultation with the optometrist or for diagnostic tests including glaucoma and cataract screening. Patients receiving AMD injections were also seen in the outpatients department.

We inspected this service using our comprehensive inspection methodology. We have reported our inspection findings against the two core services of Surgery and Outpatients. We carried out the announced part of the inspection on 8 and 9 August 2017, along with unannounced visits to the hospital on 16 and 21 August 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.

The main service provided by this hospital was surgery and outpatients. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

We rated this service as requires improvement overall because:

- We found that the provider was not effectively managing medicines in order to provide safe care and treatment to patients.
- We found there was no risk assessment, policy or procedure for safe use for use of Mitomycin. Mitomycin is an anti-cancer medication, although ophthalmology is not one of its licensed uses, it is used for clinical procedures including refractive eye surgery and glaucoma. This medication poses a risk to staff and patients, if not handled safely. Staff we spoke with did not demonstrate they were aware of these risks.
- We were not assured systems were in place to protect patients from potential risks after administration of medicines in the hospital. The process for recording medicines to be given to patients preoperatively and on discharge was not clear, presenting a risk that medicines may be given to patients incorrectly. Prescriptions concerning eye drops did not contain information regarding the quantity to be administered; therefore, staff could not make this decision safely.

Summary of findings

- The provider did not ensure that staff responsible for the management and administration of medication were suitably trained and competent. Medicines were being administered by staff without any written prescription or patient specific direction. This was a risk to patient safety as patients were receiving medicines from staff who were not competent in their administration.
- Not all staff had completed basic life support training. This meant that patients could be at risk in the event of a medical emergency.
- We were not assured that processes to ensure informed consent was obtained from patients were effective. Most patients were not provided with enough relevant information about their procedure or treatment to allow them to understand the potential risks and complications and to make an informed decision. Patient records did not contain key information detailing what discussions had taken place with patients about the possible outcomes or complications of surgery.
- We were told patients were not given any written information on the procedure they would be having and there were no written records to evidence patients were aware of the likely outcomes of their surgery.
- We found that there was no process in place to review staff competencies or to ensure that they worked within the scope of their qualifications and competence. The hospital director told us that there was no review process in place. There was no formalised competency assessment process to ensure staff had the adequate skills and knowledge to care for patients in the pre-assessment and recovery area of theatres. This meant that patients were at risk of being exposed to individuals who may not be appropriately qualified or otherwise not fit, to carry out their role.
- We were not assured that there were effective processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others. Systems to identify, record and control risks were not well embedded.
- It was not clear how oversight of risks was being maintained. There was limited evidence of discussion on risk taking place at governance meetings. Of the 37 risks recorded on the hospital's risk register, 34 did not have an assigned 'risk owner' and none of the risks had a recorded next review date. We were not assured that risks were always identified and addressed in a timely way.
- We found that the leadership lacked oversight of the quality and safety of the services provided. There was no internal clinical audit of medications undertaken by staff and therefore no assurance provided that medications were being managed safely and appropriately. Staff told us that they had raised concerns regarding local medicines administration practices but that no action had been taken to address their concerns.
- The leadership was not aware of the training requirements within the organisation's safeguarding policy. The safeguarding lead and the hospital director had not completed the required level of safeguarding training.
- We reviewed other policies and found that many, including the organisation's resuscitation policy and infection prevention and control policies, were not up to date with current legislation or guidelines. This demonstrated a lack of a robust system to review policies and processes to ensure they remain fit for purpose.
- There were often delays due to consultants not arriving on time and clinics over-running. Staff recognised that patients at the end of the session lists could be waiting for long periods. However, the hospital did not collect information on waiting times, although there was an informal system to note delays in flow through the clinics. We were told that work was ongoing to consider how improvements could be made.
- There were no care pathways in place for patients with dementia or learning disabilities. Staff had not had any training in caring for patients with a learning disability or dementia awareness and there was no flagging system in place to identify patients with additional support needs.
- There were no patient leaflets available in the outpatient reception area covering a range of common eye conditions and treatment options. There was no information to advise patients where they could obtain information about their eye conditions and no information on whether these could be provided in alternative formats.

Summary of findings

However, we also found areas of good practice:

- We found the leadership team were open and honest about where they felt the hospital needed to improve and responded proactively to the concerns we raised.
- We found a cohesive and supportive leadership team, with well-established members of staff. Staff were complimentary about the support they received from their managers and commented that they were visible and approachable.
- Staff were proud of the organisation as a place to work and spoke highly of the supportive culture. Staff we spoke with were happy with their working environment felt they all worked well together as a team.
- The majority of staff knew the process of reporting and investigating incidents. Staff understood and fulfilled their responsibilities to raise concerns and report incidents as well as near misses and were supported to do so.
- Results from the patient feedback survey undertaken by the hospital indicated patients were satisfied with the care they received.
- Patients were positive about their interactions with staff and the care they received within the department. They told us they were treated with dignity and respect.
- There was evidence of learning from the complaints received from patients and families. We saw that complaints were shared with staff at team meetings. Patients reported that they were satisfied with how to make a complaint and how they were dealt with.
- Staff assessed patient's needs and delivered care in line with current evidence based guidance and national guidance for best practice**.** The service audited the outcomes of every patient who had surgery at the service. The service measured outcomes service wide as well as for each individual consultant.
- The hospital had an eye sciences department, whose role was to collate data on refractive lens exchange (RLE), cataract surgery and laser surgery. The eye sciences team collected data for all Optegra hospitals each quarter and presented the data across the UK. Data collected would include operative details; pre-operative, post-operative and clinical outcomes.
- The service provided pre-planned services only. Therefore, they were in control of the numbers of patients they could accommodate at any given period. The service proactively forward planned surgical and clinic sessions and used data to identify number of patients and staffing requirements.
- The service provided a 24-hour helpline for advice to patients outside of normal working hours. Consultants were available during normal working hours to review patients if staff felt medical input was required.
- The environment was clean and well presented, procedures were in place to prevent the spread of infection and equipment was well maintained and appropriate for the service.

Following this inspection, we issued the provider with a Warning Notice for breaches of the Health and Social Care Act 2008 Regulations. We told the provider that it must take action to comply with the regulations by 6 October 2017. We also told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report. Following the Warning Notice, CQC returned to the provider on 10 October 2017, to review progress and found that improvements had been made.

Amanda Stanford
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	Surgery and outpatients and diagnostic imaging were the only activities at the service. Surgery was the main activity of the hospital. Where our findings relate to both activities, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with outpatients and diagnostic imaging. We rated surgery overall as requires improvement.
Outpatients and diagnostic imaging	Requires improvement 	Surgery and outpatients and diagnostic imaging were the only activities at the service. Surgery was the main activity of the hospital. Where our findings relate to both activities, we do not repeat the information but cross-refer to the surgery section. Staffing was manged jointly with outpatients and diagnostic imaging. We rated outpatients and diagnostic imaging overall as requires improvement.

Summary of findings

Contents

Requires improvement

Optegra London

Services we looked at
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Optegra London

Optegra London is operated by Optegra UK Limited. The hospital primarily serves the communities of North London. It also accepts patient referrals from outside this area.

The hospital provides an outpatient service and day surgery only. Patients were assessed, operated on and discharged within a day. There were no beds at the hospital, as patients did not stay overnight.

The hospital provides a comprehensive service to both NHS and self-referring patients covering the complete patient pathway, from ophthalmic consultations and diagnostics through to disease management or treatment including day surgery for adults only. These include refractive, ocular plastic and retinal diagnostic and surgical services and ophthalmic disease management.

NHS patients were either referred by their GP or optometrist. Private patients self-refer to Optegra. Enquiries come via email, phone or website and were booked into Optegra Patient administration software by the patient services centre.

Optegra London provides NHS eye services, mainly cataract surgery, for 13 NHS Clinical commissioning groups (CCGs).

The hospital is registered to provide the following regulated activities:

The hospital has had a registered manager in post since 2014. The current registered manager is also the director of this hospital.

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

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Lucy Davidson, two other CQC inspectors, and two specialist advisors with expertise in ophthalmic surgery and theatre management. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection

Information about Optegra London

During the inspection, we visited consulting, treatment and diagnostic rooms, patient preparation and recovery areas and both operating theatres. We spoke with 16 staff including; registered nurses, health care technicians, reception staff, medical staff, operating department practitioners, and senior managers including the hospital director. We spoke with six patients and two relatives.

During our inspection, we reviewed 18 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Activity (1 August 2016 to 31 July 2017)

- For the period 1 August 2016 to 31 July 2017, there were a total of 1,156 surgical procedures recorded at the hospital of these 54% were NHS-funded and 46% other funded.
- The most common procedures were cataract procedures, with 568 NHS cataract procedures and 242 private cataract procedures recorded during the reporting period.
- During the same period, there were 138 laser eye procedures, 124 refractive lens exchange procedures and 74 other procedures including AMD injections and vitreoretinal procedures.

Summary of this inspection

- There were 2,406 outpatient attendances in the reporting period; of these 47% were other funded and 53% were NHS-funded.

Fourteen consultants and one optometrist worked at the hospital under practising privileges. The hospital employed one ophthalmologist, one optometrist, three registered nurses, three health care technicians (HTCs) and two receptionists. The hospital also used both bank and agency staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Between August 2016 and July 2017 the hospital reported;

- There were two Never events reported with no degree of harm. One reported in the pre-inspection information and during the inspection we identified a further serious incident which should have been recorded as a notifiable incident (Never event).
- The hospital reported one serious incident in the pre-inspection information that occurred in April 2017 and two further serious incidents were reported in July 2017. One relating to the wrong lens inserted in a patient and an incident where medication went missing. All with low or no harm.
- There were no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA),Clostridium difficile (c.diff) or hospital acquired E-Coli.
- There were 32 recorded complaints.

Services provided at the hospital under service level agreement:

- Clinical and non-clinical waste removal
- Interpreting services
- Laser protection service
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- Decontamination services

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?

Inadequate

We rated safe as inadequate because:

- The provider failed to properly and safely manage medicines in order to provide safe care and treatment to patients. Safety systems and processes were not fit for purpose. This meant that patients were at increased risk of harm.
- The provider did not sufficiently prioritise patient safety. There was limited measurement and monitoring of safety performance. Staff did not assess, monitor or manage risks to people who use the services. Therefore, opportunities to prevent or minimise harm could be missed.
- We were not assured systems were in place to protect patients from potential risks after administration of medicines in the hospital. The process for recording medicines to be given to patients preoperatively and on discharge was not clear, presenting a risk that medicines may be given to patients incorrectly.
- The provider had not ensured that staff responsible for the management and administration of medication were suitably trained and competent. Medicines were being administered by health care technicians without any written prescription or patient specific direction. This was a risk to patient safety as patients were receiving medicines from staff who were not competent in their administration.
- Discharge information we reviewed did not consistently include sufficient relevant information about medicines given to patients throughout their treatment at the hospital.
- We found there was no risk assessment, policy or procedure for safe use for use of Mitomycin. Mitomycin is an anti-cancer medication, although ophthalmology is not one of its licensed uses, it is used for clinical procedures including refractive eye surgery and glaucoma. This medication poses a risk to staff and patients, if not handled safely. Staff we spoke with were unaware of these risks.
- Not all staff had completed basic life support training and no member of staff was trained in advanced life-support training or equivalent. This did not meet the standards recommended by The Royal College of Anaesthetists as set out within the Provision of Ophthalmic Anaesthesia Services, 2017. This meant that patients could be at risk in the event of a medical emergency.

Summary of this inspection

- Managers, nursing and medical staff were not up to date with safeguarding adults and safeguarding children's training.

However:

- The majority of staff knew the process of reporting and investigating incidents. Staff understood and fulfilled their responsibilities to raise concerns and report incidents as well as near misses and were supported to do so.
- Some staff had awareness in the process of duty of candour. Staff explained that patients should be informed an incident had occurred, informed of the investigation and given an apology.
- The hospital maintained standards of cleanliness and hygiene and we observed all areas of the hospital to be clean and tidy.

Are services effective?

Requires improvement 

We rated effective as requires improvement because:

- We were not assured that processes to ensure informed consent was obtained from patients were effective.
- Patients were not always provided with enough relevant information about their procedure or treatment to allow them to understand the potential risks and complications and to make an informed decision. Patient records did not contain key information detailing what discussions had taken place with patients about the possible outcomes or complications of surgery.
- We found that there was no process in place to review staff competencies or to ensure that they worked within the scope of their qualifications and competence. The hospital director told us that there was no review process in place. There was no formalised competency assessment process to ensure staff had the adequate skills and knowledge to care for patients in the pre assessment and recovery area of theatres. This meant that patients were at risk of being exposed to individuals who are not appropriately qualified or otherwise not fit, to carry out their role.
- We reviewed the hospital's policies and found that many, including the organisation's resuscitation policy, practising privileges policy and infection prevention and control policies, were not up to date with current legislation or guidelines.

However:

Summary of this inspection

- The hospital had an eye sciences department, whose role was to collate outcome data on refractive lens exchange (RLE), cataract surgery and laser surgery. The eye sciences team collected data for all Optegra hospitals each quarter and presented the data across the UK.
- Patient procedures and care pathways we reviewed cited and included relevant best practice guidance such as National Institute for Health and Care Excellence (NICE) guidance for the treatment of glaucoma and macular diseases.
- Laser protection processes were monitored, reviewed and audited via the providers training tracker mechanism. We saw the two laser protection supervisors were up to date with training.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance and national guidance for best practice**.**

Are services caring?

Good

We rated caring as good because:

- Results from the patient feedback survey undertaken by the hospital indicated patients were satisfied with the care they received.
- We saw staff treated patients with compassion and care. Patients told us they were treated with dignity and respect.
- Staff provided emotional support when dealing with sensitive information and referred patients to their GP or external support organisations where appropriate.
- Staff delivered results from investigations and assessments in a sensitive and thoughtful manner.

However:

- Information on support groups such as Royal National institute for Blind (RNIB) who provide advice to people with sight loss was not readily available.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- There were often delays due to consultants not arriving on time and clinics over-running. Staff recognised that patients at the end of the session lists could be waiting for long periods. However, the hospital did not collect information on waiting times.

Summary of this inspection

- There were no care pathways in place for patients with dementia or learning disabilities. Staff had not had any training in caring for patients with a learning disability or dementia awareness and there was no flagging system in place to identify patients with additional support needs.
- There were no patient leaflets available in the outpatient reception area covering a range of common eye conditions and treatment options.
- We did not see information available in large print or other languages. The provider subsequently informed us that there were copies of patient information leaflets in the five most commonly used foreign languages printed out and available in wallets behind the reception desk.
- Staff told us they rarely used the translation service and instead relied on the patient's family or friends, which is not best practice.
- It was unclear how long NHS patients waited from referral to initial appointment.

However:

- Services were organised in a way that met patient's needs.
- The service provided pre-planned services only. The service proactively forward planned surgical and clinic sessions and used data to identify number of patients and staffing requirements.
- There was evidence of learning from the complaints received from patients and families.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The service did not have effective systems in place to monitor and improve the quality and safety of the services provided at the hospital. Governance frameworks were not effective in supporting the delivery of good quality care. The delivery of high quality care was not assured by the leadership or governance in place. Improvements were not always identified or action not always taken in a timely way.
- Systems to identify, record and control risks were not well embedded. It was not clear how oversight of risks was being maintained as there was limited evidence of discussion on risk taking place at governance meetings.

Summary of this inspection

- We asked to see, and were not provided with, any risk assessment, policy or procedure for safe use for staff to follow when using and preparing Mitomycin. The hospital director told us a policy was in the process of being developed and was currently only available in draft form.
- We found that the provider lacked oversight of the quality and safety of the services provided. There was no internal clinical audit of medications undertaken by staff and therefore no assurance provided that medications were being managed safely and appropriately. Staff told us that they had raised concerns regarding local medicines administration practices but appropriate action had not been taken to address their concerns.
- The safeguarding lead and the hospital director had not completed the required level of safeguarding training as detailed in their organisations safeguarding policy.
- We found that there was no process in place to review staff competencies or to ensure that they worked within the scope of their qualifications and competence.
- The organisation's practicing privileges policy was not up to date containing references to out of date legislation. We reviewed other organisational policies and found that many, including the organisation's resuscitation policy and infection prevention and control policies, were not up to date with current legislation or guidelines. This demonstrated a lack of a robust system to review policies and processes to ensure they remain fit for purpose.
- There were no clear set of vision and values for the service. Most staff we spoke with were unable to tell us what the vision or values for the service were.

However:

- We found the leadership team were open and honest about where they felt the hospital needed to improve and responded proactively to the concerns we raised.
- We found a cohesive and supportive leadership team, with well-established members of staff. Staff were complimentary about the support they received from their managers and commented that they were visible and approachable.
- Staff were proud of the organisation as a place to work and spoke highly of the supportive culture. Staff we spoke with were happy with their working environment felt they all worked well together as a team.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Inadequate	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Requires improvement

Surgery

Safe	Inadequate
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

Are surgery services safe?

Inadequate

The main service provided by this hospital was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We rated safe as **inadequate.**

Incidents

- The hospital had a system in place for reporting and recording significant events. The majority of staff we spoke with knew the process of reporting and investigating incidents. Staff understood and fulfilled their responsibilities to raise concerns and report incidents as well as near misses and were supported to do so.
- The hospital reported 70 incidents in the period 1 August 2016 to 2 August 2017. These included accidents (such as a fall), administration errors, medicine errors and equipment issues as well as information governance issues and near misses.
- The hospital had not followed best practice guidance in ensuring they reviewed or recorded the level of harm for each incident. The incident log did not indicate the level of harm caused by these incidents however, it did show what actions were taken and how learning was shared from these events.
- In the 12 months prior to our inspection there had been three serious incidents (SIs) recorded by the hospital. We reviewed the root cause analysis investigations for these serious incidents. We saw that the investigation was thorough and identified areas for improvement Actions had been implemented to reduce the risk of a similar occurrence.
- Between August 2016 and August 2017 the service reported one never event however during the inspection we reviewed the serious incidents recorded by the hospital and found one SI that met the criteria for a notifiable incident and should have been reported to CQC. The patient required another operation to fit the correct lens. Both incidents were caused by the wrong lens being inserted. We saw evidence that the hospital had fully investigated both incidents and complied with Duty of Candour requirements.
- Never events (notifiable incidents) are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- We saw examples of meeting minutes which confirmed managers discussed learning from incidents and complaints with staff. Although we saw evidence that learning from incidents was shared with staff during staff meetings, some staff we spoke with commented they did not get to know about outcomes from all incidents unless they were directly involved.
- Managers told us that when things went wrong with care and treatment, patients were informed of the incident and were given information. This meant they were complying with the duty of candour requirement. However, patients were not told about any actions to improve processes to prevent the same thing happening again. The duty of candour is a regulatory duty that relates to openness and transparency and requires

providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The hospital did not use a clinical quality dashboard to monitor safety or patient outcomes.

Cleanliness, infection control and hygiene

- The hospital maintained standards of cleanliness and hygiene and we observed all areas of the hospital to be clean and tidy.
- The hospital carried out regular audits to ensure the recommended standards of cleanliness in the laser/ clinical treatments rooms and theatre environment were maintained in line with the Royal College of Opthalmologist (RCOphth) professional standards and guidance.
- The hospital had an infection control policy in place however this had not been updated to reflect current legislation and guidance. There had been no incidence of healthcare acquired infection in the last 12 months.
- Staff monitored the cleanliness of toilets and general surgical areas. Cleaning staff completed daily general cleaning checklists to confirm which areas had been cleaned. The external cleaning company carried out regular audits. These demonstrated high levels of compliance. Domestic staff we spoke with told us they received regular feedback about these audits and were aware when improvements were needed.
- Clinical areas we visited were visibly clean, tidy, well organised and mostly clutter free. We observed staff washing their hands, using hand gel between patients and observed staff complying with the 'bare below the elbows' policy.
- Managers told us they did not complete regular hand hygiene audits. One audit had been completed over the last 12 months in June 2017. The audit did not give information on the number of staff audited. However, it identified several areas for improvement including that hand hygiene was not part of the induction process and that staff had been observed wearing jewellery and nail varnish. It was unclear what plans were in place to address these issues as this information was not recorded.
- Personal protective equipment, such as gloves and hand-washing facilities were available. We observed staff using personal protective equipment appropriately, and in line with: Health and Safety Executive (2013) Personal protective equipment (PPE): A brief guide. INDG174 (Rev2). London: HSE.
- The manager told us all staff completed mandatory training in infection prevention and control training. Training records verified that staff were up to date.
- Spillage and cleaning products were available to staff**.** The hospital followed the national patient safety agency (NPSA) colour coding scheme for cleaning materials. The NPSA recommend that organisations adopt this code as standard in order to improve the safety of hospital cleaning and ensure consistency and provide clarity for staff. This ensured these items were not used in multiple areas, therefore reducing the risk of cross-infection.
- There were systems in place for the segregation and correct disposal of waste materials such as sharp items. Sharps containers for the safe disposal of used needles were available in each consulting room. These were dated and were not overfilled. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- The service had a contract with an external organisation for the removal and replacement of sharps boxes in order to make sure that these were safely dealt with.
- Laser refractive surgery was performed in a minimal access intervention operating environment. A log was kept of temperature and humidity conditions demonstrating that equipment was being maintained consistently and safely.

Environment and equipment

- Theatres practices met the Association for Perioperative Practice (AfPP) guidelines. The humidity and temperatures in theatre and treatment areas were monitored and the records kept were accurate and up to date. All the equipment we saw was clean and well maintained.
- Equipment in theatres and in ward areas was up to date and portable appliance tested (PAT) according to regulation. In theatres, there was a daily checklist

completed which included the checking of the equipment and the environment. The checks included the operating lights, microscopes, diathermy and temperatures and ventilation in the theatres.

- The hospital used single-use, sterile instruments as appropriate. The single use instruments we saw were within their expiry dates. The service had arrangements for the sterilisation of reusable instruments. This service was contracted out and monitored through a service level agreement with external provider.
- The theatre department used three different types of laser machines and protective eye goggles were colour coded to identify which machine these were to be used for**.** Staff had received training in laser protection and there were completed documentation tools to assess staff competency. This ensured they complied with the optical radiation safety guidance.
- Laser warning signs were used to clearly identify controlled areas where lasers were in use and we saw that these automatically switched-on when the door to the controlled area was closed.
- There was a laser safety management file held in the administration office of the hospital which included the laser protection advisor's (LPA's) contact information should it be required. All staff knew the location of the folder to contact if required. The folder was updated annually by the LPA or more frequently if there were changes to staffing or types of laser used.
- We saw local rules were in place to cover the use of the lasers located in the hospital. These rules describe the procedures to be followed when using lasers, plus required maintenance schedules and timescales for equipment to be serviced. We saw that staff had signed the register to confirm they had read and understood the local rules. All signatures were up to date.
- We saw resuscitation equipment available in all clinical areas with security tabs present and intact on each. We saw checklists completed daily with no omissions. An asset register was kept for all equipment. Records showed that equipment and medical devices where maintained and serviced in line with manufacturers' instructions.
- There were robust systems in place to monitor contracts and service level agreements with external contractors to facilitate the effective running of the hospital. The hospital had agreements in place for clinical waste management and disposal, laundry, cleaning and estates management.
- There were safe practices in place for the traceability of implants used in surgical procedures. Implants bar codes with unique traceable reference numbers were recorded in patients' medical records. A separate list was also kept for easy reference. Patients were given a card to keep which contained the barcodes and unique reference numbers for their own lens implants.

Medicines

Medicines information also relates to the outpatients and diagnostics service inspection.

- We found that the service did not have effective systems in place to manage medicines in order to provide safe care and treatment to patients.
- Staff did not follow their own medicines administration policy which required patient group directions (PGD) to be in place to administer medication. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. These PGDs can act as a direction to a nurse to supply and/or administer prescription only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. All the service's PGDs had expired in November 2016. Managers told us they did not need a PGD to administer medication and it had been a corporate decision not to use them across all Optegra UK sites. At the time of our inspection the hospital's medicines policy had not yet been updated to reflect this change.
- Not all staff had the required competencies to undertake the work they were carrying out. We found that health care technicians (HCTs) were administering eye drops to patients unsupervised and without a prescription or valid patient service direction (PSD). HCTs were given verbal instruction on the clinic day by the optometrist and the HCT wrote eye drops instructions on what drops to go into which eye on the patient name on the clinic list. This was shredded when finished with. Written records were not kept of what had been given to individual patients. Managers told us HCTs were able to administer eye drops to patients because they had been given instruction by the optometrist however, we found that instruction was only given verbally and was not documented. As there was no written instruction, this did not follow the organisation's

own policy or comply with the Human Medicines Regulations, 2012. This was a risk to patient safety as patients were receiving medicines from staff who were not competent in their administration.

- We saw that the process for recording medicines to be given to patients preoperatively and on discharge was not clear, presenting a risk that medicines may be given to patients incorrectly. During the inspection we reviewed four patients' treatment records. These were pre-printed with the medicines required for each surgeon's procedure and each form listed a dose of diazepam. Staff told us that this would only be given to the patient if the doctor had initialled this as required. Staff acknowledged there was a risk a dose could be given to a patient in error as not all surgeons used diazepam. The list included eye drops to be given to patients, we saw that not all had clear instructions for the dose or intervals at which they should be given by staff.
- One of the forms had the following eye drops listed: G. Proxymetacaine 0.5% was listed as '1 drop before theatre' however for one patient we saw there were three signatures at 15 minute intervals. The nurse we spoke with told us this was the prescribed dose but it was not clear from the instructions. G. Cyclopentolate 1% had no dose and was signed as given three times at 15 minute intervals. G. Phenylephrine 2.5% had no dose and was signed as given three times at 15 minute intervals. G. Iodine was listed as '1 drop before theatre' but this was not signed at all. The nurse said these were administered in theatre and we were shown a separate piece of paper with this information on. This meant that patients were at risk of harm, as they may not receive the appropriate dose of medication.
- The organisation's medications policy stated, "all registered nurses (RNs) and HCTs …should receive annual medicines management training. They must complete the competency for instilling eye drops." And "12.7 Delegation to Healthcare Assistants and Technicians (HCT): There are some circumstances where administration of certain medicines may be delegated to a healthcare technician". It goes on to state, "all delegated tasks require a signed and completed competency framework." This framework clearly stated the skills and knowledge required to undertake administration of medicines and determine the level of competency, confidence and knowledge base required to be able to administer the medicine safely. The hospital director told us that there was no process in place to review staff competencies to ensure they were up to date with the required training.
- We found that following surgery nurses were dispensing prescribed medicines from the hospital stock supplies. Whilst the Nursing and Midwifery Council gives provision for this practice as being within nurses' scope of practice. The guidelines state that this must be in the course of the business of a hospital, and in accordance with a registered prescriber's written instructions and covered by a standard operating procedure. It also states that the patient has the legal right to expect that the dispensing will be carried out with the same reasonable skill and care that would be expected from a pharmacist. We saw that this policy was not being followed and there was no process in place to ensure all HCTs and RNs had the required competencies to administer medicines to patients.
- There were no patient specific directions in place (PSDs). A PSD is the traditional written instruction, signed by a doctor, dentist, or non-medical prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. The Specialist Pharmacy Service (SPS) states that these directions must be written and that a verbal instruction is not a valid PSD.
- There are no individual prescriptions written for any medicines used in surgery or outpatients. This included use of medication for sedation (Temazepam and Diazepam), Mitomycin, and those dispensed on discharge, for example antibiotic drops. Staff told us they had raised concerns about lack of prescriptions but said they had not been listened to.
- Mitomycin had been used in surgery 16 times in the 12 months prior to our inspection. Its main use is in cancer treatment but Mitomycin may also be used for other purposes. Ophthalmology is not one of its licensed uses although it is used for clinical procedures including refractive eye surgery and glaucoma
- This medication poses a risk to staff and subsequent patients, if not handled safely. Cytotoxic drugs, including Mitomycin, are hazardous substances, as defined by the Control of Substances Hazardous to Health Regulations 2002 (COSHH). Under COSHH, employers must assess the risks from handling cytotoxic drugs for employees

and anyone else affected by this type of work, and take suitable precautions to protect them. We found there was no risk assessment, policy or procedure for the safe use of Mitomycin.

- Theatres were not cleaned after the drug was used which posed a risk to patients and staff. The COSHH regulations state employees handling cytotoxic drugs must be given suitable and sufficient information, instruction and training, relevant to their work. Employees must be made aware of the risks of working with cytotoxic drugs and the necessary precautions. Staff we spoke with appeared unaware of the risks to themselves and others when dispensing this medication in theatre.
- Staff told us there was no written protocol to follow and no policy on the use of Mitomycin. We were not assured decontamination and disposal arrangements in place were appropriate and were following COSHH guidance on safe practice.
- There was no accurate list of what medicines should be in the stock cupboard and no record kept of drugs administered to individual patients. Once a month there was a stock check by external corporate pharmacy. The external pharmacy were unable to provide a list of drugs that should be in the stock cupboard. When we checked the stock list provided by head office we found at least five other medicines in the stock cupboard that were not on the list. This meant there was a risk medicines could be removed or used inappropriately.
- There was no internal clinical audit of medications undertaken by staff and therefore no assurance provided that medications were being managed safely and appropriately. Staff told us that they had raised concerns regarding local medicines administration practices but that no action had been taken to address their concerns.
- Pre -surgery most patients were given drops to dilate their eyes. It was not clear how many drops of each medication staff patients should receive. Records did not indicate what dose of medication patients had been given.
- Patients were not given any information leaflets on what to do should they have any side effects. The pre-assessment information we saw provided by the patient had limited information recorded on the patients' health conditions. We were not assured systems were in place to protect patients from potential risks after administration of medicines in the hospital.

Records

- The hospital had systems in place to ensure all notes made by consultants working under practising privileges were included on the patients' records. Information recorded in either clinical or surgical systems was printed and added to the paper notes which became the primary patient record.
- Discharge letters only recorded medication to be administered after surgery. There was no information on drops used in the patient's eye or mention of sedations given to the patient such as temazepam or diazepam prior to surgery.
- There was no single record of medicines for a patient throughout their treatment pathway. Records for different parts of the pathway were either on separate pieces of paper or on a computer record. There was no clear record of all the medications each patient had received. We reviewed GP discharge letters and saw that they did not include sufficient detail about the patient's procedure. This meant that once discharged patients were at risk of harm if they developed complications and were unable to recall what medication they had been given.
- We reviewed consent records for patients and found 11 out of 11 records we looked at had an illegible consultant signature. The consultant name was not printed in the required place which meant we were unable to identify which consultant had signed it.
- The general medical council (GMC) guidance states medical practitioners must use the patient's medical records or a consent form to record the key elements of their discussion with the patient. This should include the information they discussed, any specific requests by the patient, any written, visual or audio information given to the patient, and details of any decisions that were made. We found that there was no additional information in the patients' records detailing what discussions had taken place with patients about the possible outcomes or complications of surgery.
- Staff used paper records for all appointments. Some basic information such as personal details and copies off discharge letters were also kept on the patient electronic record.

- Records reviewed contained copies of any referral letters and clinic letters that would be needed for any consultation. Additionally there were copies of post-treatment letters that were sent on behalf of patients to other relevant medical professionals.
- Paper notes were stored alphabetically and securely onsite until patient discharge when they were archived with a specialist record management company.
- Patient care records generated in outpatients such as treatment information were kept within the department and were easily accessible and stored securely in locked cupboards. Electronic records were only accessible to authorised people. Computers and computer systems used by hospital staff were password protected.
- Patients that were treated across Optegra sites had electronic records. Patients signed a registration form which expressed their wishes regarding communication with their GP and informed them of the potential uses of their records.
- We saw that appropriate records were maintained each time a laser was operated and appropriate patient pre-operative assessment were recorded.

Safeguarding

- The organisation's safeguarding policy stated that all staff should be trained to level 2 in safeguarding adults. We reviewed the content of the safeguarding training provided to staff and found that it did not meet the definition of level 2 training. The registered manager told us they had not been aware the mandatory training staff completed was not at the level required by the organisation's safeguarding policy. When we returned on the unannounced part of the inspection, we were told that the organisation had purchased a level 2 e-learning safeguarding adults training package and all staff had been instructed to complete the course within two weeks.

- The registered manager told us that the clinical services manager (CSM) was the hospital's local designated safeguarding lead. The organisation's safeguarding policy stated that the hospital director and the local safeguarding adult lead (CSM) should receive additional training, to level 3 standard. The registered manager told us that the clinical services manager and the hospital director had not received any additional safeguarding training above the level of training that frontline staff had undertaken.

- Not all consultants were up to date with training including safeguarding adults training. Three out of 14 consultants, recorded as having active practising privileges at the hospital at the time of our inspection, were not up to date with safeguarding adults and child protection training.
- All permanent staff and eight out of 10 bank staff had completed the "Introduction to Safeguarding Adults and Children" level 1 training. The hospital policy stated all staff must be trained to "level 2- Supporting, Safeguarding Adults Pathways". Not all staff had received safeguarding training that was relevant, and at a suitable level for their role.

- We saw there were safeguarding policies and procedures to follow and staff knew who their safeguarding lead was if they had any concerns. There was a national corporate safeguarding lead available to provide advice and oversight.
- Safeguarding training was included as part of the mandatory training package and staff told us they knew where to find information should they need to. There were no safeguarding incidents reported in the last 12 months.

Mandatory training

- We were not assured systems to monitor staff training were effective. The service had a mandatory training policy. Staff were required to have annual refresher courses for basic life support, manual handling, fire awareness, infection control amongst others. It was the responsibility of the registered manager (hospital director) to ensure staff training was up to date. The organisation's corporate policy did not stipulate the frequency of training and the manager told us this was up to the hospital to decide how often training such as safeguarding adults and children should take place.
- Full information on all mandatory training completion rates were not available at the time of our inspection as details on training staff had undertaken was not all in one place. The manager told us they were in the process of collating all the information into a spreadsheet however, this was not yet complete.
- Training records provided by the hospital showed that all permanent staff had completed fire safety awareness, manual handling, display screen equipment, equality and diversity, conflict resolution, infection control, introduction to safeguarding adults

and children, mental capacity act, deprivation of liberty safeguards, basic life support and information governance training. Most bank staff had completed the majority of the required training.

- The hospital policy on medicine management stated that staff "should receive annual medicines management training". Where tasks were delegated for example "instilling eye drops" by HCTs then these required a signed and completed competency framework. This framework should clearly "state the skills and knowledge required to undertake administration of medicines and determine the level of competency, confidence and knowledge base required to be able to administer the medicine safely." We saw that this policy was not being followed and that there was no process in place to ensure HCTs and staff in general achieved the required competencies to administer medicines to patients.
- We found that some non-permanent staff did not have basic life support (BLS) training which put patients at risk in the event of a medical emergency. The organisation's induction and mandatory training policy stated that all staff including bank staff must have basic life support training. The organisation's resuscitation policy stated, "All staff who have therapeutic contact with patients will receive training in (as a minimum), adult basic life support (as currently detailed by the Resuscitation Council UK). This will be repeated every 12 months" and that managers must "Ensure that transient staff (Bank, Locum, agency etc.) have received training in adult basic life support in the last 12 months.
- However, a review of staff training records identified that five of the 14 consultants, and three of the eight bank nurses, and had not completed BLS training within the previous 12 months. The provider's records showed that for these staff their BLS training had expired between two months and two years prior to our inspection. One bank nurse did not have any date recorded for BLS training being previously completed. Although the provider later told us that two of the five consultants without BLS training were no longer currently active in the hospital, however this did not meet the requirements of the organisation's policies.

Assessing and responding to patient risk

- The service did not routinely weigh patients and so did not calculate BMI, therefore did not use BMI as exclusion criteria. As they did not weigh patients, they could not determine if maximum weight restriction for certain pieces of equipment were being observed.
- The provider had exclusion criteria which they applied to all referrals to ensure they risk assessed patients prior to accepting the referral and offering appropriate treatment. The hospital had a criteria for refusing patients with certain health conditions and this was checked with the patient at their initial appointment. Patients completed a pre- appointment medical questionnaire ensuring the hospital had the relevant health information needed to contribute to the assessment and suitability for treatment. All necessary diagnostic tests were completed on the first appointment along with an assessment with the consultant. Only if deemed suitable were patients offered surgery.
- The hospital had a 'World Health Organization (WHO) Surgical Safety Checklist Policy' in place. We observed staff were compliant with this policy, and the overarching principles of the WHO surgical safety checklist and the National Patient Safety Agency (NPSA) 'five steps to safer surgery' guidance. Managers were aware there had been variable compliance with the WHO checklist and had recently undertaken additional training with staff to reinforce the processes to be followed.
- The WHO checklist forms part of every patient treatment pathway and was audited monthly by the clinical services manager (CSM) through a documentation audit. An audit of 10 sets of patient notes selected at random from the current month was carried out by the CSM. This included checks on whether the WHO checklist was available and that had it been documented in the patient's notes.
- A staff briefing was held prior to each surgical session. This was attended by all staff involved in the surgery in theatre. The meeting reviewed a brief summary of each patient undergoing surgery and highlighted any specific issues or concerns, such as any notable past medical history or comorbidities, any changes to the theatre list or specific equipment required for a particular case.
- Patients in the outpatients department visiting the optometrist for pre and post-surgery diagnostics were required to have their eyes dilated. Staff raised concerns

that they had no information leaflet to give to patients informing them of the type of medication drops used in their eye and what to do should there be any side effects. Staff told us they had raised the lack of information leaflets as a risk to managers over a year ago.

- The hospital provided a 24-hour advice line which patients could telephone following their surgery. However, they were advised to seek emergency medical assistance for more serious matters following discharge.
- The hospital had an anaphylaxis policy in place with a standard operating procedure of what should be done in the event of an incident; this was readily accessible to and familiar staff.
- There had been no incidence of unplanned transfer of care within the last 12 months. If medical input was required staff were told to contact the emergency services.
- Patients who had undergone local treatments at the hospital were given written discharge patient information which included the on- call number in the event of any patient concern. This number was available 365 days a year.
- The organisation's resuscitation policy did not refer to the latest resuscitation guidance. The registered manager told us that no member of staff was currently trained in advanced life-support training or equivalent. This did not meet the standards recommended by The Royal College of Anaesthetists as set out within the Provision of Ophthalmic Anaesthesia Services, 2017 that states that staff should be trained in basic life support and there should be at least one person with advanced life-support training or equivalent.

Nursing and support staffing

- There were four permanent registered nurses and three health care technicians employed at the hospital. Most staff worked across outpatients and surgery when needed. The hospital used regular bank nursing and optometrist staff to cover shifts in outpatients.
- Managers did not use a formalised staffing acuity tool to determine numbers of staff required. The CSM assessed and anticipated the numbers of staff required based on the number and type of procedures that were being undertaken for that session. This information was then used to plan and schedule the appropriate numbers of nursing staff required.
- Staff told us there were enough staff on duty to maintain patient safety and this was confirmed by staff rotas we looked at. However, staff told us they rotated across surgery and outpatients departments and often worked long shifts as surgery and clinics often overran.
- The hospital had its own 'bank' of temporary staff that could be called upon when required. Data provided by the hospital prior to our inspection recorded that bank staff had covered 86 nursing shifts during the period January to March 2017.
- Sickness rates were recorded at hospital level only. The average rate of sickness between May 2016 and July 2017 was 2.73% for nurses, 0.8% for health care technicians the hospital had no vacancies for permanent staff as the one vacant post had been recently recruited.

Medical staffing

- The hospital directly employed one ophthalmologist and had 13 ophthalmologist consultants who worked across surgery and outpatients under the practising privileges scheme.
- The service followed "The Professional Standards for Refractive Surgery" (2017), aimed at surgeons and other medical professionals. This provides clear guidance on the level of experience and knowledge refractive surgeons should have, as well as the environment for performing surgery safely, good communication and teamwork and continuity of care. These standards were implemented in June 2017.
- We saw that the provider had checks in place to ensure any new surgeon employed or granted practising privilges at the hospital, held the requird level of training and experience to allow them to perform refractive eye procedures. All surgeons who performed refractive eye surgery were required to either hold a certificate in laser and refractive surgery (CertLRS) or be on the GMC Specialist Register in Ophthalmology, and hold evidence in their last revalidation cycle of an established refractive surgery practice.
- Medical oversight was maintained by the Optegra national medical director from whom advice could be sought on corporate medical matters. Local medical supervision was available from the MAC chair who through the committee reviewed and monitored clinical practices across the hospital.
- At least one laser protection supervisor (LPS) was on site whenever laser procedures took place. Cases were

booked into regular and designated lists where possible which allowed for accurate planning. Monthly rotas were utilised and staffing planned against activity. Skill mix including LPS was allocated on a daily basis by the theatre lead and clinical services manager.

- Staff had access directly to the operating consultant, in addition to other consultants with practicing privileges. They were able to contact the 24 hr on call lead nurse and the clinical services manager should that be required. For each sub specialty, there was more than one consultant practicing within the hospital. Consultants were required to arrange suitable colleague cover when they were not available.
- Patient specific input could be sought through from consultants who were available by telephone. Where the patient's own consultant was not available, cover was provided by another consultant with the same clinical speciality.
- Although the service did not accept emergencies, a consultant or doctor was available during usual opening hours to review patients who might be experiencing difficulties post-operatively.

Emergency awareness and training

- The hospital had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.
- All staff had access to annual fire training and the manager explained the evacuation procedure for outpatient's clinics. Back-up generators for lasers ensure treatment was not compromised if power failed mid-treatment.

Are surgery services effective?

Requires improvement

We rated effective as **requires improvement.**

Evidence-based care and treatment.

- We reviewed the hospital's policies and found that many, including the organisation's resuscitation policy, practising privileges policy and infection prevention and control policies, were not up to date with current legislation or guidelines.
- Patient procedures and care pathways we reviewed cited and included relevant best practice guidance such as National Institute for Health and Care Excellence (NICE) guidance for the treatment of glaucoma and macular diseases
- Staff were kept up to date with changes in practice and used this information to deliver care and treatment, which met patient's needs. For example, staff received National Patient Safety Alerts and alerts from the Medicines and Healthcare products Regulatory Authority. This meant they had accurate and up to date information confirming that best practice guidance was used to improve care and treatment and patient's outcomes.
- Local audit activity centred on laser projections audits. There was limited other local audit activity. The hospital director told us they were looking at setting up more audits however these were not yet in place and not dates were available when they would start

Pain relief

- Where appropriate staff administered anaesthetic eye drops prior to surgery or procedures. Patients were asked about pain levels during and after procedures.
- Patients were advised on pain relief during discharge discussions and told that if the pain was severe they should go to their local accident and emergency department. Patients we spoke with stated that their pain was monitored and treated appropriately.

Nutrition and hydration

- All patients were day patients and food was not required to be provided. However, nursing staff offered drinks and snacks to patients pre and post operatively.

Patient outcomes

- The hospital did not participate in any national audits and did not contribute to the National Ophthalmic Database Audit (NODA). The purpose of NODA is to collate anonymised data collected as a by-product of routine clinical care using electronic medical record (EMR) systems for the purposes of national audit, research and establishing meaningful measures for revalidation.
- The hospital did not engage with the Private Healthcare Information Network (PHIN) so that data could be submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA).

All providers of private healthcare in the UK, including most NHS hospitals, are required by law to submit data to PHIN. The registered manager told us their eye science division were leading on this and they hoped to be involved later this year.

- Posterior capsule rupture (PCR) is a recognised complication of cataract surgery, occurring in around 1 in 50 patients (just less than 2%). Rates are higher in those with known risk factors, for example dense cataract. The hospital recorded that there had been 17 occurrences out of 1,129 procedures over the last 12 months prior to our inspection, which was a rate of 1.5% and better than the national average.
- However, whilst PCR is accepted as a common complication of cataract surgery there are set procedures that must be followed by surgeons to address this. The hospital told us they had no specific protocol for managing PCR. This meant that staff might not be aware of the most up to date guidance and recommendations provided by NICE and the Royal College of Ophthalmologists.
- The hospital has had five incidence of unplanned re-treatment or treatment enhancement following refractive eye surgery in the last 12 months. Four for "laser top up" treatment and one lens exchange to improve vision.
- There was one incident of an unplanned return of a patient to theatre following refractive eye surgery in the last 12 months.
- Optegra UK corporate leadership maintained an 'eye sciences' division, which amongst other activities managed the collection and reporting of clinical data from the hospital. Data collected included information on clinical complications, visual and refractive outcomes for laser, lens replacement and cataract patients.
- Of 183 refractive eye treatments, 1.1% patients had experienced complications following refractive eye surgery in the last 12 months. This information, along with other outcome data, was used to benchmark the hospital's performance against other Optegra hospitals.
- Surgical outcomes collated by the eye sciences division were shared with the hospital director. Then discussed and reviewed at the hospital Medical Advisory Committee (MAC), and also reviewed at the quarterly corporate governance committee.
- Quality clinical reports were discussed at the hospital governance committee and hospital MAC – the agenda covered areas such as incidents, never events, serious incidents, returns to theatre, unplanned outpatients and transfers.
- Patient reported outcomes were also measured following discharge of patients. These were monitored over time and benchmarked across hospitals and Optegra UK. The service audited the surgical performance of each individual surgeon and patient outcomes were collated to ensure they were meeting best practice standards. Outliers were investigated and action plans created as required.
- Data information was captured using information on the electronic patient record (EPR) system and reported at quarterly meetings of the senior leadership board, medical advisory committees (MAC), and at both hospital and corporate governance committees. Managers told us they used industry standard for cataracts, laser and refractive laser eye (RLE) patients.

Competent staff

- We examined the arrangements in place to determine that staff were competent to undertake their assigned roles. We reviewed staff training records for all permanent, bank and agency staff as well as staff working under practising privileges at the service. We found that there was no process in place to review staff competencies or to ensure that they worked within the scope of their qualifications and competence. The registered manager told us that there was no review process in place. This meant that patients could be exposed to individuals who are not appropriately qualified or otherwise not fit, to carry out their role.
- The organisation's practising privileges policy stated, "The Clinic Manager and its Managing Director are required to review the practice privileges of each Practitioner every two years" and "The decision to renew practice privileges should be taken on behalf of the Clinic by the General Manager on advice from the MAC Chairperson. The decision should be confirmed in writing, for inclusion in the consultant's folder."
- A review of records found that 10 of the 14 consultants with active practising privileges were granted these more than two years prior to our inspection. We saw no documentation for any of these consultants to evidence that their practising privileges had been reviewed as required by the organisation's policy. The registered

manager told us that there was no process in place to ensure consultants had completed their revalidation. This meant that patients were at risk of being exposed to individuals who are not appropriately qualified, or otherwise not fit, to carry out their role.

- The clinical staff matrix competency spreadsheet showed that not all permanent registered nurses and HCTs were up to date with all clinical competencies. The hospital relied on bank nurses to cover operating lists and many had incomplete competencies information in their folders. For example, two out of three bank nurses had not completed the theatre scrub competency and five out of seven staff had incomplete competencies for discharge.
- We reviewed staff records for five permanent staff (two registered nurses and three HCTs) as well as five bank staff, and asked to see documentary evidence of all completed competencies; these were not provided to us.
- The service had not ensured that staff responsible for the management and administration of medication were suitably trained and competent. We reviewed staff records for five permanent staff (two registered nurses and three HCTs) as well as five bank staff, and asked to see documentary evidence of all completed competencies; these were not provided to us at the time or since the inspection.
- The clinical services manager had a system for identifying which staff were competent to work in which areas of the hospital, such as those who could act as scrub nurse. However, we did not see documentation to evidence that individual staff were competent to complete specific tasks, such as the dispensing of medications to take home, nurse led discharging and pre-operative assessments. This meant that we did not have assurance that nurses were competent to perform these roles. We spoke to managers about this during the inspection and they advised us they would be working on a new system to evidence these as a priority.
- The laser protection supervisors (LPSs) attended Core of Knowledge Laser Safety training every three years unless there was a change in regulation. This was monitored, reviewed and audited via the providers training tracker mechanism. We saw the two laser protection supervisors were relevant staff were up to date with training.
- Optegra UK's lead laser protection advisor was provided by Public Health England (PHE) with whom Optegra had a service level agreement. PHE reviewed competency, local rules and provided training. They completed an annual audit and provided any action plans necessary.
- Consultants who operated the equipment and clinical team members who assisted with procedures were on the register as authorised users. Registered users signed to confirm that they have read and understood the local rules for each given laser room.
- Consultants and clinical team members had Core of Knowledge training which was monitored within the training tracker on the intranet. When any new refractive lasers were introduced consultants and staff using all refractive lasers equipment had signed off certificates of competence.
- Consultants wishing to implement any new procedures would be discussed at the MAC. If agreed as appropriate then they would be signed off by the medical director, as safe to be used.
- There was an induction programme for all newly appointed staff. Mandatory training topics included safeguarding, infection prevention and control, fire safety and health and safety.
- The learning needs of permanent staff were identified through a system of appraisals and one to one meetings. The manager told us most staff were up to date with their appraisal. Staff we spoke with told us they had regular appraisals.

Multidisciplinary working

- During our inspection, we saw good multidisciplinary teamwork between disciplines within the hospital. There appeared to be a sense of respect and recognition of the value and input of all team members.
- Most staff worked across both surgery and outpatients departments. Staff explained that they worked together as a team and knew about each other's roles and responsibilities in the hospital.
- The hospital had effective relationships with community eye practitioners such as optometrists and opticians.
- Patients referred for assessment and treatment of cataracts were seen by a consultant, a nurse, and also had any necessary tests, for example having their blood pressure taken. Staff aimed to ensure that essential tests were all completed on the same day in one appointment. Staff told us that optometrists and ophthalmic consultants worked well together.

- The hospital shared relevant information with other services in a timely way, for example when referring patients to other services.

Seven day services

- The hospital was open from Monday to Friday between 8am and 6pm and Saturday mornings on an occasional basis.
- The service provided a 24-hour helpline for advice to patients outside of normal working hours. Consultants were available during normal working hours to review patients if staff felt medical input was required.

Access to information

- Optegra used an electronic based clinical record system which was accessible from all Optegra locations. The system held records of clinical information including scans which upload to the system. This meant that if a patient required a follow up appointment at a different location to where their refractive eye surgery was originally performed medical information would be easily accessible.
- NHS patients from the local CCG were seen for follow up appointments at a local community service clinic. This site was separately registered with CQC and was not included in this inspection. We were told that the clinic had full, secure access to all relevant Optegra IT systems allowing a continuous patient pathway. Patients were followed up by same consultant who had operated
- Consultants were responsible for the outpatient records for their private patients and stored these off site.
- Relevant staff had access to details held on the electronic patient record and paper notes. These included pre –assessments information on patient's medical history, medications, allergies, referral letters, consent information and pre- surgery notes, and any consultants' operation notes.
- Paper records were archived to an external storage facility once the patient was discharged. Documents could be recalled should they be needed after being archived.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A corporate consent policy was in place at the hospital. The policy set out staff responsibilities for seeking and obtaining informed consent, including the type of consent (verbal or written) needed for different procedures undertaken at the hospital.
- The organisation's consent policy was last reviewed by the service in December 2012 and was due for review in December 2018 according to the review log. However, we saw this policy was not up to date with current professional standards and legislation including the Royal College standards (April 2017) for refractive eye surgery which states, "A minimum cooling off period of one week is recommended between the procedure recommendation and surgery."
- We were told that consultants did not follow a consistent consent process and each consultant did things differently. We were told that one consultant did not follow the 'two step' consent process and instead consented the patient on the day of surgery. This would mean they were not following the Professional Standards for Refractive Surgery (April 2017) which states the service should ensure "informed consent is given by explaining/giving written information about all risks, benefits, realistic outcomes and costs." The service then should ensure people are given a 'period of reflection'/'cooling off' (at least one week) between agreeing to go ahead with procedure and surgery being performed.
- We reviewed consent records for 15 patients and in 11 of these saw no documentation that discussions had taken place between the consultant and the patient to make them aware of the risks and potential complications of their procedure. The consent forms had been signed by both the patient and consultant however there was no record to confirm that the patient had been provided with all relevant information about their procedure or treatment.
- We saw one consent form where the patient had signed the reconfirmation section themselves, which should have been completed by a member of staff on the day of treatment. This had not been picked up by staff at weekly surgical review meeting.
- We found that for a patient who was living with dementia, staff had not followed the organisation's consent process. We reviewed the patient's records and saw that the pre-assessment information recorded that the patient had understood the reason for their admission. The nursing pre-assessment record recorded

that the patient had hearing difficulties but stated, "Patient will understand if he is spoken to slowly and articulately in a slightly raised voice." This record also stated, "Patient has dementia and wife says this issue must not be raised with patient". However, we saw that there was no documented record of any conversation on consent taking place with the patient. Information on the why the patient was unable to consent themselves was not recorded. A best interests decision had been made on the patient's behalf however we saw that the documentation was incomplete and there was no evidence of who else had been consulted other than the patient's wife. There was no written evidence of any attempts to discuss consent with the patient. This did not meet the requirements of the organisation's consent policy.

- It is good practice to ensure that consent is agreed and secured well in advance, so that patients have plenty of time to obtain information about the procedure and ask questions. We were told patients were not given any written information on the procedure they would be having and there were no written records to evidence patients were aware of the likely outcomes of their surgery. For example, one patient we spoke with told us they had given consent for their operation but were not aware that they would not have good vision after their cataract operation. They said this had not been discussed with them. They had returned for a follow up appointment and we observed staff talking them through why they did not have the outcome they expected and would need to get glasses to be able to see.
- Staff had raised concerns that because they had no written information to give to patients on their pre-assessment visit and most patients having cataract surgery were not aware they would need glasses after surgery. The NHS contract only allowed for single vision lens to be inserted, which meant most patients, would require glasses after surgery. Staff told us they frequently had the same conversations with patients when they returned for their post-surgery visit to explain to the patient why their expectations had not been met.
- The hospital director told us that there was an information booklet available to all patients however, staff we spoke with said this was not provided to all patients. We spoke with two patients who were attending the hospital following their cataract surgery and both said they had not received any written information about the possible risks and complications of the procedure.
- Most staff were unable to tell us if they had training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards legislation. Some staff though it might have been included on the basic level one safeguarding adults training. However, staff we spoke with were not clear about their roles and responsibilities. Staff responses were variable and several staff thought it was about health and safety issues.

Are surgery services caring?

Good

We rated caring as **good**.

Compassionate care

- Patients we spoke with were positive about the care they had received and told us nurses and doctors were kind and compassionate. Patients told us they had been put at ease by staff with one patient commenting that the “staff were fabulous” and had explained their procedure in a way they could understand.
- All staff we observed during pre-assessment appointments and during the checking in process were kind and respectful towards patients, taking their time to ensure they answered questions and concerns in full.
- The hospital used ‘Trust pilot’ which is an independent provider of reviews for healthcare and other services to gather feedback from patients about their refractive eye surgery. The hospital did not participate in the NHS Patient-led Assessments of the Care Environment (PLACE). The hospital conducted its own internal version of the NHS Friends and Family Test. Data provided by the hospital showed that of 97 responses between December 2016 and July 2017, 99% of patients would recommend the service to their family or friends. Feedback comments were consistently positive.
- We observed all staff, including reception staff and non-clinical staff were kind and caring towards patients who used the service.

Understanding and involvement of patients and those close to them

Requires improvement

Surgery

- All patients we spoke with said they were aware of their surgical procedure and that it had been explained to them thoroughly and clearly. Patients told us they had been given time to ask questions to ensure understanding.
- Patients told us that staff kept them informed about the waiting times and how many patients were ahead of them on the theatre schedule.
- Staff told us that private patients received written information prior to surgery to ensure they felt supported and prepared for surgical procedures. However, not all private patients were offered a seven-day 'cooling off' period to ensure that they had time to fully understand and consider all the information available.
- Not all patients we spoke with had fully understood their expected outcomes following surgery. For example two patients thought they would no longer need to wear glasses after surgery. They said they had not been told that might be the realistic outcome before giving consent to the operation.
- During the surgical procedures, we observed staff explained what was happening during each stage of the procedure and checked on the patient's welfare.
- Staff ensured that patients had the support they needed following a procedure and involved those close to patients to ensure they were supported when they returned home.
- We observed staff taking time to explain follow up care and instructions to patients and to answer their questions following surgery. This included how to correctly insert eye-drops at home, they also advised on take home medication details and after-care such as bathing and cleaning the eye.

Emotional support

- Staff ensured people's privacy and dignity were respected throughout the patient pathway.
- Staff were aware if patients were feeling anxious. Patients could wait in another area with a member of staff who supported them throughout their assessment or treatment if required. This ensured patients' wellbeing was taken into account as well as their physical health.
- All consultations and care related conversations took place in private rooms where discussions would not be overheard.
- The service provided clear information on pricing for different surgeries. Following surgery refractive eye patients were provided with written information explaining their follow-up care.
- After surgery all patients were given contact details of who to call if they had any concerns.

Are surgery services responsive?

Requires improvement

We rated responsive as **requires improvement.**

Service planning and delivery to meet the needs of local people

- The clinic provided a range of eye treatments including, refractive eye surgery. Patients completed a comprehensive pre- assessment questionnaire prior to attending for their first consultation.
- Patients were contacted by telephone one week before appointments to ensure all information was current and nothing had changed.
- The hospital used a pre-admission checklist to identify patients who may have had a previous heart attack or stroke, or who may require help with moving around. This was used to plan their treatment on the day and ensure there consultation was with the most appropriate health care professional.

Access and flow

- The hospital did not provide an emergency eye surgery service. They provided for elective and pre-planned procedures only. Any emergency cases were referred to the appropriate emergency eye care services.
- Patients were able to access the service via a range of means. Self-paying and insured patients were able to self-refer without a GP or optician's referral. Thirteen local NHS clinical commissioning groups (CCGs) commissioned services from the hospital for appropriate NHS patients.
- NHS patients followed the NHS patient pathway which included an assessment of suitability and triage by a clinician. These patients required a GP or optometrist referral. For some procedures, NHS patient could choose this service through the NHS e-referral programme (known a 'choose and book').

Requires improvement

Surgery

- All necessary diagnostic tests were completed on the first appointment along with an assessment with the consultant. If deemed suitable patients were offered surgery and added to the waiting list.
- NHS patients were notified of their appointments by the NHS administration team. Self-pay and insured patients were either referred by their GP, optometrist or they had self-referred.
- Patient details were recorded on the electronic patient database and confirmation of the appointment sent out. All new appointments received a welcome call to confirm the patient's next appointment. The appointment letter included a map of the clinic with directions and parking information. A patient registration form and a medical questionnaire were also included. Two patients we spoke with confirmed this.
- There was no waiting list for refractive eye surgery. No refractive eye surgery procedures had been cancelled for a non-clinical reason in the last 12 months.
- There was a system in place to ensure admission processes took account of the criteria for admission. There was a list of exclusion criteria where patients with specific health conditions were not deemed suitable for treatment at the hospital.
- Patients completed a pre- appointment medical questionnaire ensuring the hospital had the relevant health information needed to contribute to the assessment and suitability for treatment.
- Telephone triage clinic appointments were in place to review patient's self-assessment information prior to surgery.
- The pre- assessment clinic was led by the optometrist and nurses. Patients were able to see the nurse or health care technician and have the appropriate health and diagnostic tests completed. For example basic observations, blood pressure etc.
- Staff aimed for patient appointments to take between one to two hours and the lead nurse monitored arrival and assessments times. Staff commented there were often delays due to consultants not arriving when they should do hence patients had to wait. We were told that some consultants were regularly late to arrive both for pre- assessment clinic and on surgery days. It was unclear what was being done to ensure consultants arrive on time.
- The patient's surgical pathway was planned during pre-assessment. This ensured patients could consider whether dates for surgery and post-surgery appointments were appropriate and new dates could be considered according to patient preference to ensure flexibility.
- Patients arrived on the morning or afternoon of their planned surgery day. Most morning patients arrived at 8.30am and afternoon patients at 2pm. The hospital had changed its booking slots to ensure there were two patients for each slot for cataract operation. This was to ensure consultant time was efficiently used and reduced delays in flow through the clinic.
- The consultant saw all patients prior to their operation. Patients and staff recognised that patients at the end of the session lists could be waiting for long periods. Work was ongoing to consider how improvements could be made.
- Patients were kept informed of the list order and how many patients were in front of them. Patient flow through theatres had improved through staff reviews of the patient's journey. All patients who had procedures under local anaesthetic without sedation would go straight back from theatre to the day surgery ward for discharge.
- All patients were treated as a day case under a local anaesthetic or sedation.
- Private patients including those on the refractive treatment pathways for laser had an average waiting time of two to five weeks subject to laser and refractive consultant availability. Patient treatment was scheduled in the same way regardless of being NHS or private patient and medically urgent patients, were treated as soon as possible as a priority.
- Private patients could arrange a free no obligation consultation with ophthalmologists to discuss potential treatments and procedures. They could also attend 'open evenings' were consultants would give a presentation and discuss the various treatments.
- Nurses discharged patients following surgery after ensuring patients had recovered and were fit to go home. If they had any concerns, they could request a review by the surgeon involved.
- Patients told us they could book their follow up appointments during their pre assessment clinic visit. This ensured patients could identify times to suit them and to fit around their schedules.
- A copy of the discharge letter was given to patients on leaving the hospital. Copies were also sent to the

patient's GP and or optometrist/optician. The letter recorded the procedure the patient had and details of any post-surgery medication they had been given to take home with them.
- Patients were advised regarding post-operative care, how to use the medicines provided and given details of the 24-hour helpline should they have concerns following discharge.
- Follow up appointments were arranged as outpatients at clinic for reviews.
- Managers told us they rarely cancelled operations. Usually only for clinical staff sickness or very occasionally staff sickness. Management records were not kept of the number of sessions cancelled. Staff said they rebooked patients as soon as possible and always within a few days of the cancellation for the next available clinic.

Meeting people's individual needs

- The organisation's consent policy stated that for patients whose first language is not English, "There will be a translator facility available at Optegra; however, this must be pre-arranged and will be at a cost to the patient. The cost and arrangements will be discussed with the patient and agreed prior to confirmation." However, we were told that staff usually relied on the patient's family to translate for them. This was not best practice and it was unclear how this policy applied to NHS patients and whether this meant they could not access the service if they did not pay for it. Staff told us they rarely used the translation service. The registered manager subsequently confirmed that payment was not required and that there would be a translator facility available at Optegra, however, this must be pre-arranged.
- Each patient had an allocated patient liaison (PL) member of staff who would act as the liaison between the consultant and patient should there be any queries or concerns that need to be addressed.
- The surgery service were not proactively considering specific individual needs, including patients with complex needs and cultural and religious requirements. However, staff we spoke with were able to give examples of how they met the needs of different patients.
- There were no care pathways in place for patients with dementia or learning disabilities. Staff told us how they would adapt their responses according to the patients needed. Examples given to us included, ensuring patients were early on the theatre list and allowing relatives and carers to accompany patients into theatres on the day of their procedure.
- Staff had not had any training in caring for patients with a learning disability or dementia awareness.
- There were no adaptations in the environment for people living with dementia. For example, appropriate signage. However, staff were available to escort patients where they needed to go throughout the building and to support them with any needs they might have.
- Management and staff we spoke with were not aware of any specific dementia or learning disability strategy.
- Hearing loops were available for patients with hearing impairment if required.
- There was no flagging system available on the appointment booking system. This meant staff were unable to identify patients, and make preparations, if extra help or adjustments were needed. Staff told us that if the patients had a triage call this would identify any additional needs and would be recorded in the pre assessment information.
- A wheelchair was available for patients who may require it. There were no specific arrangements in place for bariatric patients however staff told us they discussed people's needs on the telephone triage appointment. Should additional help or equipment be needed this would be provided.
- The outpatients and diagnostics department was on the ground floor and the operating theatres were the first floor. A lift was available for easy access for people with that required it. Patients were asked if they have any special requirements to access the building during their pre assessment consultation.
- Patients had access to tea and coffee making facilities and water was available at all time.

Learning from complaints and concerns

- The hospital had a system for handling complaints and concerns and followed the organisation's corporate complaints policy which provided a structured process for staff to follow when dealing with complaints. We reviewed the policy and found it had recently been reviewed and was in line with recognised guidance and contractual obligations for independent hospitals in England.
- The service had received 32 written compliments in the last 12 months. Of these, seven were managed under

the formal complaints procedure, four of which were upheld. Examples were given by staff of changes made in response to complaints including changes to booking processes to reduce waiting times for patients.

- We were told that many complaints could be resolved informally by discussing the issue with a member of staff. If the issue remained unresolved then the complainant was invited to follow the formal complaint procedure. A letter confirming receipt of the complaint was sent out within two working days. A full response was usually made within 20 working days of receipt of the complaint. If there were going to be any delays then a further letter was sent to the complainant to explain why this is the case. An extension of time is agreed with the complainant. The complaints procedure is included within the 'patient guide' which was available in the reception area.
- The patient and clinical services managers were responsible for responding to complaints before they became formal and the hospital director (registered manager) was responsible for responding to formal complaints.
- Managers told us complaints, compliments and learnings from incidents were shared at hospital and team meetings and actions recorded. We looked at meeting minutes that confirmed this.
- Details of complaints were shared within the governance structure at the medical advisory committee (MAC) and integrated governance meetings. Informal complaints were shared at the daily meeting with staff .
- Patient feedback was encouraged through friends and family questionnaires. Patient feedback forms (compliments and complaints) were available in all patient areas.

Are surgery services well-led?

Requires improvement

We rated the well-led as **requires improvement.**

Leadership of this service

- The service was led by the hospital director who was also the hospital's registered manager. The hospital director reported directly to the Optegra UK managing director.
- The hospital had a patient services manager and clinical services manager who were responsible for managing front-line staff and reported directly to the hospital director.
- There were lines of management responsibility and accountability within service. Staff described who their line managers were and their individual roles and responsibilities. Staff told us they all worked well together as a team.
- Staff told us that local leadership was good and managers were approachable and supportive.

Vision and strategy

- The hospital had a statement of purpose which shared its vision and values with patients. Their objective was to be the "most trusted" eye care provider, putting patients at centre of what they did.
- Most staff were unable to tell us what the vision or values for the service were.
- The registered manager told us their strategic aim was to provide appropriate service and care for each patient in the best environment and at the right time. Care would be provided by the colleague who was competent and best placed to deliver that care.

Governance, risk management and quality

- The hospital director was the location lead for governance and quality monitoring. They were supported by the clinical services manager who provided the quarterly performance and quality reports.
- We found that the leadership lacked oversight of the quality and safety of the services provided at the location. There was a general lack of local audit, including lack of auditing waiting times for patients when delays had been identified as a problem by patients and staff. There was no internal clinical audit of medications undertaken by staff and therefore no assurance provided that medications were being managed safely and appropriately. Staff told us that they had raised concerns regarding local medicines administration practices but that no action had been taken to address their concerns.
- We were not assured that there were effective processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others. There were 37 open risks recorded on the hospital's risk register at the time of our inspection. Of these, four had been on the register since 2015 but had

no details recorded of the progress against the action plan or the controls in place to mitigate these risks. One of these risks, which had been open since November 2015, referred to the lack of a service level agreement (SLA) in place with a local hospital to provide emergency eye cover if required. We found that there was no SLA in place at the time of our inspection and the registered manager told us this had been reviewed with local trusts and found not to be necessary. The risk register did not reflect this risk assessment. Of the 37 risks, 34 did not have an assigned 'risk owner' and none of the risks had a recorded next review date.

- We reviewed three sets of governance meeting minutes dated September 2016, February 2017 and May 2017 and found that although the risk register was a standing agenda item there was limited evidence of discussion on risk taking place. In the meeting minutes dated February 2017 it stated, "risk register is updated by management" and " this needs to be reviewed by hospital management" however, in the next meeting minutes dated May 2017 the risk register agenda item was left blank with "n/a" recorded. Of the 37 risks on the risk register, 23 had been added to the risk register on the same day, 22 May 2017. However, there was no evidence of these being reviewed within the minutes of the governance meetings held on 3 and 23 May 2017. Therefore, it was not clear how oversight of risks was being maintained.
- We identified that the cytotoxic drug, Mitomycin, was prepared and used by staff to treat patients at the service. This medication poses a risk to staff and patients, if not handled, stored and disposed of safely. We asked to see, and were not provided with, any risk assessment, policy or procedure for safe use for staff to follow when using and preparing Mitomycin. The hospital director told us a policy was in the process of being developed and was currently only available in draft form. We were not assured that decontamination and disposal arrangements were following COSHH guidance on safe practice.
- We reviewed the hospital's policies and found that many, including the organisation's resuscitation policy, practising privileges policy and infection prevention and control policies, were not up to date with current legislation or guidelines. This demonstrated a lack of a robust system to review policies and processes to ensure they remain fit for purpose
- The organisation's practising privileges policy stated, "The Clinic Manager and its Managing Director are required to review the practice privileges of each Practitioner every two years" and "The decision to renew practice privileges should be taken on behalf of the Clinic by the General Manager on advice from the MAC Chairperson. The decision should be confirmed in writing, for inclusion in the consultant's folder." A review of records found that ten of the fourteen consultants with active practising privileges were granted these more than two years prior to our inspection. We saw no documentation for any of these consultants to evidence that their practising privileges had been reviewed as required by the organisation's policy. The registered manager told us that there was no process in place to ensure consultants had completed their revalidation. This meant that patients were at risk of being exposed to individuals who are not appropriately qualified, or otherwise not fit, to carry out their role.
- The organisation's practising privileges policy contained out-of-date legislation. The policy stated, "This Policy should be read in conjunction with the Care Standards Act 2000, the Private and Voluntary Health care Regulations 2001 with the National Minimum Standards." This legislation has been replaced by the Health and Social Care Act 2008 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This policy also stated, "Those granted practice privileges are "independent contractors" and are not employees, agents or sub-contractors of the clinic. Optegra accepts no liability for the acts and defaults of Practitioners or their employees." This does not meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which sets out that individuals granted practising privileges by a service provider will be considered as employed by that service provider.
- The hospital had processes in place to ensure all new clinical staff had verified references however, these were not effective. We looked at eight staff files for consultants with practising privileges and found that five contained no references and three contained only one reference instead of two. This meant we could not be assured the appropriate recruitment checks had been completed as required by the hospital's own policies and procedures.
- Only six out of 14 files had evidence of a valid DBS check being completed by the organisation. Although the

other consultants did have evidence of a DBS certificate, these checks were carried out by a previous employer and dated more than three months (and in one case several years) before their practising privileges were granted at the hospital.

- We reviewed 11 consultant's practising privileges files for evidence of reference checks and found that five contained no references (although there was evidence these had been requested) and three contained only one reference (although two had been requested). There was no evidence of a documented risk assessment or review by the medical advisory committee (MAC) to record why the decision had been made to grant practising privileges despite the lack of references.
- The registered manager told us that the clinical services manager (CSM) was the hospital's local designated safeguarding lead. The organisation's safeguarding policy stated that all staff should be trained to level 2 in safeguarding adults. We reviewed the content of the safeguarding training provided to staff and found that it did not meet the definition of level 2 training. The policy also stated that the hospital director and the local safeguarding adult lead (CSM) should receive additional training, to level 3 standard. The hospital director told us that they had not completed any additional safeguarding training above the level of training that frontline staff had undertaken. The hospital director was not aware of these additional training requirements within the organisation's safeguarding policy.
- All consultants and staff who work under rules or practicing privileges at the location had an appropriate level of professional indemnity insurance in place.
- Ophthalmologists who worked under rules or practicing privileges at the location were not allowed to invite external staff to either work with them or on their own.
- There were structures in place to maintain clinical governance and risk management. For example, medical advisory meetings (MAC) were held quarterly, however these were not effective. The MAC did not track various performance systems including; ensuring consultants with practicing privileges were up to date with statutory and mandatory training and ensuring they had sufficient consultant time to deliver the service in a timely way.
- Surgical outcomes were collated by the organisations eye sciences division and shared with the hospital director. We saw they were discussed and reviewed at the hospital's medical advisory committee (MAC), with individual consultants, and at the corporate governance committee on a quarterly basis.
- Systems and processes in place to ensure laser safety were robust and regularly monitored. Laser safety was a standing agenda item. Any incidents or concerns were discussed and learning shared through hospital or team meetings.
- Senior staff were able to describe the actions taken to monitor patient safety and risk. This included incident reporting, completing regular audits, sharing learning and feeding back to other staff. However, most staff were not aware of quality measurement and were not involved in audits. Some nurses were aware of hand hygiene audits however, they were not able to discuss any involvement in improvement audits.
- Monthly performance reports identified trends in performance and included a range of topics including cancelled operations, finance and complaints.

Culture within the service

- Throughout the inspection, staff were welcoming and willing to speak with us. Staff were proud of the organisation as a place to work and spoke highly of the supportive culture.
- Staff spoke positively about the service they provided for patients. They were proud of their customer service and the way they worked as a team.
- Staff told us they were encouraged to raise concerns and had a clear understanding of who to raise these concerns with. Managers told us they had an open door policy and staff echoed this telling us they felt comfortable addressing concerns or improvement ideas.
- Staff progression was not evident within surgical and outpatient areas of the service. Information on whether nurses had access to external courses and were encouraged to find and apply for learning opportunities which interested them was unavailable.

Public and staff engagement

- The service had a website where full information could be obtained about the treatments available for patients. It was very comprehensive including information about costs and finance. The Optegra website advertised a free no obligation quote, to assess private patients' suitability for refractive eye surgery.

Requires improvement

Surgery

- Staff described examples of how services at the location had been changed and improved as a direct result of the views and experiences of people using the service. For example, changes had been made to the patient pathway to reduce waiting times for patients.
- The hospital completed its own regular patient surveys to gain feedback using different methods including collecting written and verbal feedback. Staff had access to an iPad in reception which enabled them to quickly capture people's views. Family or friends were invited to accompany patients on their consultations and to feedback their views.
- Between April and July 2017, 39 of 54 patient feedback forms were received and 79% of patients were satisfied with the services provided by the patient services centre, 89% satisfied with the services provided by the clinical team and 87% of patients were seen at their scheduled appointment time. Overall, 84% of patents rated their experience as positive.
- An annual colleague engagement survey was conducted with the results shared openly with colleagues and action plans developed. Optegra had a staff recognition scheme whereby staff could nominate individuals and teams.
- The hospital held open evenings periodically when the public were invited to view the facilities and ask any questions regarding the process and procedures.

Innovation, improvement and sustainability

- The leadership team were keen to drive continuous improvement within their areas of responsibility. Staff were encouraged to share ideas, which improved the patient experience and the patient journey.
- Optegra has recently introduced a balanced score card that measures key performance (KPIs) across colleague satisfaction, impact on patients, processes and business financials. 11 KPIs were benchmarked against best practice and measured monthly. The hospital director told us that this helped staff develop personal objectives which supported the hospital's vision and values.

Requires improvement

Outpatients and diagnostic imaging

Safe	Inadequate
Effective	
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

Are outpatients and diagnostic imaging services safe?

Inadequate

We rated safe as **inadequate.**

For our detailed findings on this section please see the Safe section in the Surgery report.

Incidents

- There was a system for reporting and recording significant events. In the 12 months prior to our inspection there had been no reported never events for the outpatient or diagnostic imaging department. Between August 2016 and August 2017, there had been no clinical incidents within outpatient services. We saw minutes which confirmed managers discussed learning from incidents and complaints.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident and received reasonable support. However we were not assured that patients were told about any actions to improve processes to prevent the same thing happening again.
- Staff told us they were provided with information about incidents verbally and nursing staff told us incidents and learning outcomes were discussed at staff meetings. Staff said feedback from incidents staff had not been directly involved in was variable and they did not always get to hear the outcome of incident investigations.

Cleanliness, infection control and hygiene

- Staff monitored the cleanliness of general outpatient areas. Cleaning staff completed daily general cleaning checklists to confirm which areas had been cleaned.
- The manager told us all staff completed mandatory training in infection prevention and control training. Training records we saw verified that staff were up to date.
- Spillage and cleaning products were available to staff. Staff explained how they would clean up a spillage and showed us where spillage and cleaning products were stored. The hospital followed the national patient safety agency (NPSA) colour coding scheme for cleaning materials. These recommended organisations adopt this code as standard in order to improve the safety of hospital cleaning and ensure consistency and provide clarity for staff. This ensured these items were not used in multiple areas, therefore reducing the risk of cross-infection.
- The hospital maintained standards of cleanliness and hygiene and we observed the hospital to be clean and tidy.
- Personal protective equipment, such as gloves and hand-washing facilities were available. We observed staff using personal protective equipment appropriately.
- There were systems in place for the segregation and correct disposal of waste materials such as sharp items. Sharps containers for the safe disposal of used needles were available in each consulting rooms. These were dated and were not overfilled. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- We saw the daily cleaning schedule that identified areas to be cleaned. These included bathroom and corridor areas.
- The lead for infection control had recently left and another member of staff had been allocated that role.

They were in the process of waiting for additional training to enable them to fulfil that role. Staff knew who to contact should they need advice and have any questions about infection control.
- We reviewed the infection, prevention and control policy dated January 2015, and saw that it had not been updated with the latest COSHH guidance and European waste regulations.

Environment and equipment

- All equipment we looked at was stored appropriately.
- There was a planned preventative maintenance schedule with appropriate checks in place.
- An external maintenance team were responsible for annual safety testing. The equipment we checked had an up to date safety test and appeared in good condition.
- There was appropriate operating room and monitoring equipment**.** The service had an ongoing routine maintenance scheduled that ensured equipment was safe to use. If equipment required repair or replacement, this was promptly actioned in order to maintain the safety of patients and staff.
- Resuscitation equipment was available for use in an emergency. Staff were allocated to check resuscitation equipment and we saw that checks were recorded. Emergency medicines available on the resuscitation trolley were stored within an anti-tamper bag and regular checks completed to ensure they remained within their expiry date. We saw checks were completed and recorded to ensure that equipment was safe to use.
- There was a Laser safety policy in place. We saw evidence that the service followed guidance from the laser radiation committee and there were appropriate risk assessments in place.
- When required there was appropriate consultation with the Laser Protection Adviser Controlled Areas were clearly defined; all relevant staff understood and followed 'Local Rules'.

Medicines

For our detailed findings on medicines please see the Safe section in the Surgery report.

- We saw evidence that medicines were not always managed safely. For example, we observed one member of staff that did not have the authority to prescribe medication, dispense eye drops without a prescription.
- A prescription only drug is a pharmaceutical drug that legally requires a prescription to be completed before being given to a patient. The hospital medicine management policy stated there must be a valid prescription and "dispensing must be carried out and signed by two registered practitioners. Either by a registered nurse or doctor." This meant they were not following their own policy on dispensing drugs.
- Medicines were securely stored in locked cupboards. Lockable fridges were in place, with daily temperature checks. This meant the department followed the appropriate guidance on the safe handling and storage of medication.
- The hospital outsourced pharmacy supply services to an external provider.

Records

- Patient care records generated in outpatients such as treatment information were kept within the department when needed for treatment and were easily accessible. Once finished with these were then move to an external storage provider where they were kept until needed.
- Paper records used in the outpatient department were stored securely. Electronic records were only accessible to authorised people. Computers and computer systems used by hospital staff were password protected.
- Patient records were usually available when needed in the outpatient clinics. The reception staff managed the transfer of records in and out of the clinics. There was a tracking system in place to ensure that the location of individual records could be identified.
- Electronic records contained copies of information sent to private patients regarding the costs of their treatment in order to provide the patient with relevant information before they agreed to the treatment.
- Discharge information we reviewed did not consistently include relevant information about medicines. Patients were given verbal information, on when and how to take the prescribed medicine. However, this was not recorded in the patients' records in order to make sure that this information was consistent and fully understood by the patient.

Requires improvement

Outpatients and diagnostic imaging

Safeguarding

For our detailed findings on Safeguarding for this core service, please see the Safe section in the Surgery report.

- The hospital did not offer appointments to children in outpatient clinics. All patients were over the age of 18.
- All permanent staff had access to basic level safeguarding adults and children's training.
- Staff understood their responsibilities and were aware of local safeguarding policies and procedures. The clinical services manager was the allocated local safeguarding lead.
- We saw that there were local and national safeguarding policies and procedures in place, which staff in the service knew how to access. Staff gave us examples where they had discussed potential safeguarding concerns with the safeguarding lead. OPD staff had raised one safeguarding concern in the previous 12 months.

Mandatory training

For our detailed findings on mandatory training please see the Safe section in the Surgery report.

- Training records provided by the hospital showed that all permanent staff had completed fire safety awareness, manual handling, display screen equipment, equality and diversity, conflict resolution, infection control, introduction to safeguarding adults and children, mental capacity act, deprivation of liberty safeguards, basic life support and information governance training. Most bank staff had completed the majority of the required training.

Nursing staffing

For our detailed findings on nursing staffing please see the Safe section in the Surgery report.

- There were four permanent registered nurses and three health care technicians employed at the hospital. Most staff worked across outpatients and surgery when needed. The hospital used regular bank nursing and optometrist staff to cover shifts in outpatients.
- The outpatient department was managed by the clinical services and patient liaison managers. Patients were met by reception staff and directed to their appointment.
- Arrangements were in place to ensure enough staff with the right skill mix were on duty to meet patient's needs.

Medical staffing

For our detailed findings on medical staffing please see the Safe section in the Surgery report.

- Consultants working at the hospital had been granted practising privileges. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. This right is subject to various checks on for example; their professional qualifications, registration, appraisals, revalidation, and fitness to practice declaration.
- The hospital employed one full time optometrist and one consultant ophthalmologist.
- Consultants covered their own outpatient clinics on a sessional arrangement.

Emergency awareness and training

- The hospital had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.
- All staff had access to annual fire training and managers explained the evacuation procedure for outpatient's clinics.

Are outpatients and diagnostic imaging services effective?

We do not currently rate the effectiveness of outpatient's services.

Evidence-based care and treatment

For our detailed findings on Evidence based care and treatment for this core service, please see the Effective section in the Surgery report.

- Patients' needs were assessed and care was delivered in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. For example, protocols were followed with regard to national guidance for cataract surgery.
- Staff were kept up to date with changes in practice. They had access to guidelines from NICE and used this information to deliver care and treatment, which met patient's needs. For example, staff received National Patient Safety Alerts and alerts from the Medicines and

Healthcare products Regulatory Authority. This meant they had accurate and up to date information confirming that best practice guidance was used to improve care and treatment and patient's outcomes.
- The hospital did not participate in any national clinical audits relevant to the outpatients department.
- Patients were assessed about their suitability for treatment by the optometrist and consultant at the pre assessment appointments.

Pain relief

For our detailed findings on pain relief for this core service, please see the Effective section in the Surgery report.

Nutrition and hydration

For our detailed findings on nutrition and hydration for this core service, please see the Effective section in the Surgery report.

Patient outcomes

For our detailed findings on patient outcomes for this core service, please see the Effective section in the Surgery report.

Competent staff

For our detailed findings on competent staff for this core service, please see the Effective section in the Surgery report.

- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. There was an induction programme for all newly appointed staff.
- Mandatory training topics included safeguarding, infection prevention and control, fire safety and health and safety.
- The manager told us all staff were up to date with their appraisal.

Multidisciplinary working

For our detailed findings on Multidisciplinary working for this core service, please see the Effective section in the Surgery report.

- Patients referred for assessment and treatment of cataracts were seen by a consultant, optometrist a nurse or health care technician, and also had any necessary tests, such as diagnostic tests. The pre-assessment visit ensured that all essential tests were completed on the same day in one appointment. Staff told us that optometrist and ophthalmic consultants worked well together.
- Discharge letters were sent to GPs following outpatient appointments that detailed the treatment given and advised of any further treatment that was planned.
- Relevant information was shared with other services in a timely way, for example when referring patients to another service.

Access to information

- Most referrals to the service were paper-based. There was no system available to receive referrals electronically and no method to monitor or audit referrals once received. Patient referrals could therefore be lost or delayed without staff realising.
- Staff had the information they needed to deliver effective care and treatment to people who used services. For example, access to policies, procedures and professional guidance. However several of these were not up to date with current legislation and best practice guidance.
- Clinic information and patient notes were accessible to relevant staff.
- We looked at how information needed for staff to deliver safe treatment was made available. We saw that patient files were made available for each appointment and for staff to monitor patients after their surgery.
- Information held on the hospital's own patient record system needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. This included care assessments and investigation and test results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

For our detailed findings on Consent, Mental Capacity Act and Deprivation of Liberty Safeguards for this core service, please see the Effective section in the Surgery report.

- We observed one consultant following the hospital policy on consent to ensure that patient consent was gained for each procedure.

Requires improvement

Outpatients and diagnostic imaging

- Staff told us doctors discussed treatment options during the consultation. Where written consent was required, this would often be obtained in the outpatient clinic. Two patients told us they had been asked for consent before their procedures.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

- Staff were friendly and professional, putting patients and their relatives at ease. We observed administration staff listening and responding appropriately to patients request in a kind and caring manner.
- Patients and relatives told us staff were helpful kind and understanding and their privacy and dignity were always respected.
- The outpatients department had suitable rooms for private consultations. Patients were admitted into individual rooms so they could discuss their procedure or treatment in private.
- We noted consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Patients said staff were helpful, polite and they were treated with dignity. One relative gave an example about her relative, where they had felt listened too, and been treated with respect by all staff. We observed clerical staff in the clinic assisted patients promptly and were friendly and efficient.
- Staff said patients were able to bring friends or family with them to their consultation. If they needed support staff would chaperone them if required. A notice in reception informed patients this service was available.
- Feedback about clinic reception staff was very positive. Patients told us the staff were very friendly and helpful.
- Reception staff were aware that patients may have to wait before being seen by medical staff. Staff told us delays did occur and we observed staff informing and apologising to patients for any delay on the day of the inspection.
- It was difficult for patients to speak to staff confidentially due to the open layout of the clinic reception desks and the treatment areas. Staff told us patients could request to speak to staff in private rooms but it was unclear how patients were expected to know this was available.
- We observed staff reassuring patients and giving them time to understand the treatment they were due to have.

Understanding and involvement of patients and those close to them

- Staff introduced themselves and we observed consultants introduce themselves and shake patient's hands when they were called in for their appointment slot.
- Patients told us they felt involved in decision making about the care and treatment on the day of their surgery. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choices of treatment available to them.
- Services were planned to meet the needs of patients. Patients had a choice of consultant ensuring continuity of care. Appointments were flexible and staff booked assessments on the same day to reduce travel for patients.

Emotional support

- We observed staff giving reassurance to patients both over the telephone and in person.
- Staff delivered results from investigations and assessments in a sensitive and respectful manner. Staff told us they were mindful that investigations indicating deterioration of a patient's eye condition could be upsetting and took care to explain the findings carefully.
- Information on support groups such as RNIB, who provide advice to people with sight loss, was not readily available. Many patients had a diagnosis of long term conditions such as age-related macular degeneration (AMD) where the patients' central vision deteriorates or glaucoma where the optic nerve is damaged by the pressure of the fluid inside the eye. Both these conditions can cause significant sight loss.
- Throughout our visit we observed staff giving reassurance to patients with additional support given when it was required, especially if patients were apprehensive.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Requires improvement

We rated responsive as **requires improvement.**

For our detailed findings on this section please see the responsive section in the Surgery report.

Service planning and delivery to meet the needs of local people

- Patients we spoke with said the waiting area in reception was comfortable. Hot and cold water and tea and coffee were available in the reception area. People could help themselves when they wanted.
- Magazines and papers were also available for patients to read.
- There were a few information leaflets but these were mainly focussed on information for private patients on cataract and refractive eye surgery.
- Patients and staff confirmed appointments were planned and booked in advance. These sessions were dependent on surgeon availability and were occasionally cancelled.
- The service used the appointment systems to plan clinic sessions to identify number of patients who would be attending each day. They used this information to decrease or increase the number of clinical appointments required to meet the needs of patients and to maintain flexibility of staff.
- The hospital identified patients who may be in need of extra support when they completed their initial assessment information. For example: patients with communication difficulties**.**
- The hospital had a dedicated member of staff whose role was to discuss with patients the finance details. They told us they discussed costs for each procedure. Patients were given full written details of the charges for their treatment and plan for treatment.
- Patient toilets were available throughout the clinic areas and immediately next to some waiting areas.
- Patients were seen in private rooms in outpatients. Private rooms were available within clinic areas and staff told us these rooms would be used if a sensitive conversation with a patient was necessary, for example if the team were breaking bad news about a patient's diagnosis.

Access and flow

For our detailed findings on access and flow please see the Responsive section in the Surgery report

- Patients accessed the outpatient's service via a referral from their GP, optometrist or self referred privately.
- There were systems in place to triage patients on the waiting list. Referrals were triaged by nursing staff.
- All necessary diagnostic tests were completed on the first appointment along with an assessment with the consultant. If deemed suitable patients were offered surgery and added to the waiting list.
- Patients completed a pre- appointment medical questionnaire ensuring the hospital had the relevant health information needed to contribute to the assessment and suitability for treatment.
- Staff told us a number of clinics frequently finished late, for example one morning clinic often ran until 3pm. One staff member told us some consultants would see patients no matter how late they arrived after their appointment time, which caused a delay to other patients. The hospital did not monitor clinic finish times and staff told us nothing had been done to address the issue.
- On arrival, patients reported to the main reception where they would then wait until collected and taken to their consultation room. There was sufficient space and flexibility for the number of patients being treated at the time of inspection.
- Waiting times for appointments were variable. Most patients were seen within 15 minutes, however nursing staff told us patients could wait longer when clinics were busy. Total visit times in outpatients were not monitored by the hospital and an estimated total visit time was not displayed at the reception desk of each clinic.
- The hospital did not collect information on waiting times however they had informal systems to note delays in flow through the clinics. The hospital's average NHS waiting time was four to eight weeks and appointments were offered to fit around patient choice and availability.

Requires improvement

Outpatients and diagnostic imaging

- There were no audits to monitor the time patients spent within the hospital. This meant they were not able to give patients an idea of how long appointments were likely to take and enable them to plan for their visit and arrange transportation.
- Staff told us that where patients missed any appointments the service contacted them within 48 hrs to follow up and rearrange an appointment as needed.
- It was unclear how long NHS patients waited from referral to initial appointment. Staff told us most patients were seen within six weeks. Hospital appointments were dependent on the clinician's availability. We asked for, but did not receive any data on how the service monitored its patient referral to treatment times.

Meeting people's individual needs

For our detailed findings on Meeting people's individual needs please see the Responsive section in the Surgery report.

- We observed that seating in the main waiting room area did not cater for patients that required different seat heights, for example patients with orthopaedic conditions.
- Bariatric chairs were not available should people require them within clinic waiting areas.
- The ground floor waiting area was spacious with separate offices that supported staff and administrators and staff to have private discussion if required. The service also had confidential interview and clinic rooms, which enabled staff and patients to have private discussions.
- There were no patient leaflets available in the outpatient reception area covering a range of common eye conditions and treatment options, including cataracts, macular degeneration, and glaucoma. Staff told us they had requested leaflets for patients from Optegra UK, publishing department over a year ago however these had not been provided. However there was information available for private patients attending outpatients on Refractive eye surgery.
- We did not see information available in large print or other languages. The provider subsequently informed us that there were copies of patient information leaflets in the five most commonly used foreign languages printed out and available in wallets behind the reception desk.
- Staff informed us that there was assistance for people who required additional support to communicate such as a loop system to assist in hearing and translation service for patients who would benefit from these services. We saw that loop system equipment was available in the majority of areas in the hospital.
- The hospital could be accessed by those who had a physical disability as there was a lift available to both floors. The OPD was on the ground floor and easily accessible for patients. Relatives were encouraged to stay with patients at all times, if required.
- Staff said patients often brought friends or family with them to the consultation. If they needed support staff would chaperone them if required. A notice in reception informed patients this service was available.
- Other than information provided by the patient on the pre assessment questionnaire and subsequent triage telephone call if required there was no flagging system in place to ensure nurses were notified in advance of patients who may have complex needs or were vulnerable, so that special arrangements could be made in advance This meant there was no reliable or appropriate system for highlighting this individual need.
- Patients told us staff provided suitable support for visually impaired patients and we observed staff providing appropriate support to meet patient needs.

Learning from complaints and concerns

For our detailed findings on Learning from complaints and concerns please see the Responsive section in the Surgery report.

- The outpatient department displayed their complaints leaflet that informed patients of how to complain. However this was available only in one format and one language.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as **requires improvement.**

For our detailed findings on this section please see the well-led section in the Surgery report.

Leadership and culture of service

Requires improvement

Outpatients and diagnostic imaging

For our detailed findings on this section please see the Well-led section in the Surgery report.

- Outpatients was led by the clinical services manager and the hospital director who reported directly to the Optegra UK managing director. Staff told us that local leadership within outpatients was good and managers were approachable, supportive and staff felt involved.
- There were lines of management responsibility and accountability within outpatient's department. Staff described who their line managers were and their individual roles and responsibilities.
- Staff in outpatients told us they worked well together as a team. Throughout the inspection, staff were welcoming and willing to speak with us. Staff spoke positively about the service they provided for patients. They were proud of their customer service and the way they worked as a team.

Vision and strategy for this core service

For our detailed findings on this section please see the Well-led section in the Surgery report.

Governance, risk management and quality measurement

For our detailed findings on this section please see the Well-led section in the Surgery report.

Public and staff engagement

For our detailed findings on this section please see the Well-led section in the Surgery report.

Innovation, improvement and sustainability

For our detailed findings on this section please see the Well-led section in the Surgery report.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must take prompt action to address concerns identified during the inspection in relation to medicine management and the governance of the service.
- The provider must ensure that risks to patients are identified, assessed and monitored consistently, and that action plans are updated and contain enough detail to enable staff to reduce those risks effectively.
- The provider must ensure they have robust systems in place to monitor the administration, management and dispensing of medicines to provide safe care and treatment to patients.
- The provider must ensure that all policies and guidance are up to date with current professional standards and legislation.
- The provider must ensure that all staff have attended mandatory training and that there are sufficient numbers of staff with the right competencies, knowledge and qualifications to meet the needs of patients.
- The provider must ensure staff are aware of their responsibilities under the Mental Capacity Act and have suitable arrangements in place for obtaining and acting in accordance with the consent of service users, or acting in accordance with the best interest principles of the Act.
- The provider must ensure staff are clear about their roles and responsibilities under legislation around capacity and deprivation of liberty.
- The provider must ensure nursing records and discharge letters are completed fully and accurately to ensure patient safety.
- The provider must ensure all staff and clinicians with practising privileges have the relevant training to ensure they have the required skills and knowledge to deliver effective care and treatment.

Action the provider SHOULD take to improve

- The provider should ensure that patient leaflets are available in other formats, such as large font or braille, and other languages.
- The provider should ensure patients are given appropriate safety information on any medication they have been given whilst attending the hospital.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent 1. Most patients were not provided with enough relevant information about their procedure or treatment to allow them to understand the potential risks and complications and to make an informed decision. Staff told us that no written information was provided to NHS patients to explain the possible risks or complications of their procedure. 2. We observed a patient being given verbal information about the predicted outcome of their procedure. When we spoke with this patient, it was clear they had not understood what they had been told. They had not understood they would not be able to see clearly without glasses after the operation. The patient and their relative told us they had not received any written information about their procedure. 3. We reviewed consent records for 15 patients and in 11 of these saw no documentation that discussions had taken place between the consultant and the patient to make them aware of the risks and potential complications of their procedure. The consent forms had been signed by both the patient and consultant however there was no record to confirm that the patient had been provided with all relevant information about their procedure or treatment. 4. We found that for a patient who was living with dementia, staff had not followed the organisation's consent process. We reviewed the patient's records and saw that the pre-assessment information recorded that the patient had understood the reason for their admission. The nursing pre-assessment record recorded that the patient had hearing difficulties but stated, "Patient will understand if he is spoken to slowly and articulately in a slightly raised voice." This record also stated, "Patient has dementia and wife says this issue

Enforcement actions

must not be raised with patient". However, we saw that there was no documented record of any conversation on consent taking place with the patient. Information on the why the patient was unable to consent themselves was not recorded. A best interests decision had been made on the patient's behalf however we saw that the documentation was incomplete and there was no evidence of who else had been consulted other than the patient's wife. This did not meet the requirements of your organisation's consent policy.

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

1. During our inspection on the 8,9,16 and 21 August 2017, we reviewed how the service undertook the proper and safe management of medicines. We found that you were failing to manage medicines in order to provide safe care and treatment to patients.

2. During our inspection on 8, 9 and 16 August 2017 we found that staff did not have the required competencies to undertake the work they were carrying out. We saw that medicines (including proxymetacaine 0.5%, phenylephrine 2.5 and topicamide 1%) were being administered by health care technicians (HCTs) without any written prescription or patient specific direction (PSD). This did not follow your organisation's own policy which states, "All patients receiving medicines must only do so under the direction of a qualified practitioner against a signed prescription, under delegated authority from the optometrist using The College of Optometrists – Optometrists' formulary August 2016 Optom formulary Standing direction signed by the consultant or against a patient group direction (PGD).Please note health care technicians are not on the list of professionals who can administer drugs against an PGD." This is a risk to patient safety as patients are receiving medicines from staff who are not competent in their administration. Therefore, you are not compliant with the Human Medicines Regulations 2012.

This section is primarily information for the provider

Enforcement actions

3. You failed to ensure that staff responsible for the management and administration of medication were suitably trained and competent. On 9 August 2017, the registered manager told us that there was no process in place to review staff competencies to ensure they were up to date with the required training. We reviewed staff records for five permanent staff (two registered nurses and three HCTs) as well as five bank staff, and asked to see documentary evidence of all completed competencies; these were not provided to us at the time or since the inspection.

4. We saw that the process for recording medicines to be given to patients pre-operatively and on discharge was not clear, presenting a risk that medicines may be given to patients incorrectly. On 21 August 2017, we reviewed four medicines pro forma. These were pre-printed with the medicines required for each surgeon's procedure. Each form listed a dose of diazepam. Staff told us that this would only be given to the patient if the doctor had initialled this as required. Staff acknowledged this process may not be clearly understood by new or temporary staff and there was a risk a dose could be given to a patient in error. Of the eye drops listed to be given to patients, we saw that not all had clear instructions for the dose or intervals at which they should be given by staff. We saw four examples of these forms. One of the forms had the following eye drops listed:a. G. Proxymetacaine 0.5% was listed as '1 drop before theatre' however for one patient we saw there were three signatures at 15 minute intervals. The nurse we spoke with told us this was the prescribed dose but it was not clear from the instructions.b. G. Cyclopentolate 1% had no dose and was signed as given three times at 15 minute intervals.c. G. Phenylephrine 2.5% had no dose and was signed as given three times at 15 minute intervals.d. G. Iodine was listed as '1 drop before theatre' but this was not signed at all. The nurse said these were administered in theatre and we were shown a separate piece of paper with this information on. This was not clear from the pro forma.This meant that patients were at risk of harm as they may not receive the appropriate dose of medication.

5. We were not assured that you were doing everything that was reasonably practicable to mitigate risks to patients. We found that some non-permanent staff did

This section is primarily information for the provider

Enforcement actions

not have basic life support (BLS) training which put patients at risk in the event of a medical emergency. The organisation's induction and mandatory training policy stated that all staff including bank staff must have basic life support training. The organisation's resuscitation policy stated, "All staff who have therapeutic contact with patients will receive training in (as a minimum), adult basic life support (as currently detailed by the Resuscitation Council UK). This will be repeated every 12 months." and that managers must "Ensure that transient staff (Bank, Locum, agency etc.) have received training in adult basic life support in the last 12 months."A review of the provider's staff training records identified that five of the fourteen consultants, recorded by the provider as having active practising privileges at the time of our inspection, and three of the eight bank nurses, had not completed basic life support training within the previous 12 months. The provider's records showed that for these staff their BLS training had expired between two months and two years prior to our inspection. One bank nurse did not have any date recorded for BLS training being previously completed. Although the provider later told us that two of the five consultants were no longer currently active in the hospital this did not meet the requirements of your organisation's policies.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. You did not ensure there were appropriate systems and processes in place to assure governance and managerial oversight of the hospital. You therefore failed to assess, monitor and improve the quality and safety of the services provided at the hospital. You also failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others including staff. 2. On 16 August 2017, we identified that the cytotoxic drug, Mitomycin, was prepared and used by staff to treat patients at the service. This medication poses a risk to staff and patients, if not handled, stored and disposed of

Enforcement actions

safely. Cytotoxic drugs are hazardous substances, as defined by the Control of Substances Hazardous to Health Regulations 2002 (COSHH). Under COSHH, employers must assess the risks from handling cytotoxic drugs for employees and anyone else affected by this type of work, and take suitable precautions to protect them. We asked to see, and were not provided with, any risk assessment, policy or procedure for safe use for staff to follow when using and preparing Mitomycin. On 21 August 2017, we again asked to see any risk assessment, policy or procedure for safe use for Mitomycin and we were told by the registered manager that a policy was in the process of being developed and was currently only available in draft form.

3. The COSHH regulations state employees handling cytotoxic drugs must be given suitable and sufficient information, instruction and training, relevant to their work. Employees must be made aware of the risks of working with cytotoxic drugs and the necessary precautions. Staff we spoke with were unaware of the risks to themselves and others when dispensing this medication in theatre. Staff we spoke with told us there was no written protocol to follow and no policy on the use of Mitomycin. They told us that theatres were not cleaned after the drug was used which posed a risk to patients and staff. We were not assured that decontamination and disposal arrangements were following COSHH guidance on safe practice.

4. We found that the hospital director lacked oversight of the quality and safety of the services provided at the location. There was no internal clinical audit of medications undertaken by staff and therefore no assurance provided that medications were being managed safely and appropriately. Staff told us that they had raised concerns regarding local medicines administration practices but that no action had been taken to address their concerns.

5. The registered manager told us that the clinical services manager (CSM) was the hospital's local designated safeguarding lead. The organisation's safeguarding policy stated that all staff should be trained to level 2 in safeguarding adults. We reviewed the content of the safeguarding training provided to staff and found that it did not meet the definition of level 2

Enforcement actions

training. The policy also stated that the hospital director and the local safeguarding adult lead (CSM) should receive additional training, to level 3 standard. The registered manager told us that the clinical services manager and the hospital director had not received any additional safeguarding training above the level of training that frontline staff had undertaken. The registered manager/hospital director was not aware of these additional training requirements within the organisation's safeguarding policy.

6. We examined the arrangements in place to determine that staff were competent to undertake their assigned roles. We reviewed staff training records for all permanent, bank and agency staff as well as staff working under practising privileges at the service. We found that there was no process in place to review staff competencies or to ensure that they worked within the scope of their qualifications and competence. The registered manager told us that there was no review process in place. This meant that patients were at risk of being exposed to individuals who are not appropriately qualified, or otherwise not fit, to carry out their role.

7. The organisation's practising privileges policy stated, "The Clinic Manager and its Managing Director are required to review the practice privileges of each Practitioner every two years" and "The decision to renew practice privileges should be taken on behalf of the Clinic by the General Manager on advice from the MAC Chairperson. The decision should be confirmed in writing, for inclusion in the consultant's folder." A review of records found that ten of the fourteen consultants with active practising privileges were granted these more than two years prior to our inspection. We saw no documentation for any of these consultants to evidence that their practising privileges had been reviewed as required by your organisation's policy. The registered manager told us that there was no process in place to ensure consultants had completed their revalidation. This meant that patients were at risk of being exposed to individuals who are not appropriately qualified, or otherwise not fit, to carry out their role.

8. The organisation's practising privileges policy contained out-of-date legislation. The policy stated, "This Policy should be read in conjunction with the Care

This section is primarily information for the provider

Enforcement actions

Standards Act 2000, the Private and Voluntary Health care Regulations 2001 with the National Minimum Standards." This legislation has been replaced by the Health and Social Care Act 2008 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This policy also stated, "Those granted practice privileges are "independent contractors" and are not employees, agents or sub-contractors of the clinic. Optegra accepts no liability for the acts and defaults of Practitioners or their employees." This does not meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which sets out that individuals granted practising privileges by a service provider will be considered as employed by that service provider. We reviewed other policies and found that many, including the organisation's resuscitation policy and infection prevention and control policies, were not up to date with current legislation or guidelines. This demonstrated a lack of a robust system to review policies and processes to ensure they remain fit for purpose.

9. We were not assured that there were effective processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others. There were 37 open risks recorded on the hospital's risk register at the time of our inspection on 8 and 9 August 2017. Of these, four had been on the register since 2015 but had no details recorded of the progress against the action plan or the controls in place to mitigate these risks. One of these risks, which had been open since November 2015, referred to the lack of a service level agreement (SLA) in place with a local hospital to provide emergency eye cover if required. We found that there was no SLA in place at the time of our inspection and the registered manager told us this had been reviewed with local trusts and found not to be necessary. The risk register did not reflect this risk assessment. Of the 37 risks, 34 did not have an assigned 'risk owner' and none of the risks had a recorded next review date. We reviewed four sets of governance meeting minutes dated 26 September 2016, 1 February 2017, 3 and 23 May 2017 and found that although the risk register was a standing agenda item there was limited evidence of discussion on risk taking place. In the meeting minutes dated 1 February 2017 it stated, "risk

This section is primarily information for the provider

Enforcement actions

register is updated by management" and " this needs to be reviewed by hospital management" however, in the next meeting minutes dated 3 May 2017 the risk register agenda item was left blank with "n/a" recorded. At the meeting on 23 May 2017 it was noted that the "risk register will be reviewed in mid-June as this was not used for a while". Of the 37 risks on the risk register, 23 had been added to the risk register on the same day, 22 May 2017. However, there was no evidence of these being reviewed within the minutes of the governance meetings held on 3 and 23 May 2017. Therefore, it was not clear how oversight of risks was being maintained.