Minor Ops Limited

MY Eye Clinic

Inspection report

Great North Road
Brunton Park, Gosforth
Newcastle Upon Tyne
NE3 5NA
Tel: 01919178886
www.minor-ops.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

My Eye Clinic is an independent provider operated by Minor Ops Limited. The service offers a range of privately funded ophthalmic treatments to patients over the age of 18. Services include general ophthalmology, cataract surgery including pre- and post-operative assessment, Ocular hypertension and glaucoma treatment and monitoring, eyelid and tear duct surgery, YAG laser treatment, medical retina services for conditions that affect the back of the eye. Oculoplastic, medical retina, and yttrium aluminium garnet (YAG) laser treatments.

YAG laser capsulotomy is a type of laser treatment that is used to make a hole in the capsule to allow light to pass through to the back of the eye to improve vision. The YAG laser is used as the final part of the cataract surgery.

Patients are mostly self-referring and pay for their eye surgery themselves. Surgery days are variable and are booked according to demand. There are no overnight facilities and clinics operate Monday to Friday, with occasional opening on weekends and evenings if there is a need to do so, as required by demand of the patients.

They also hold a contract fora community-based ophthalmology service with the local Integrated Care Board for the treatment of NHS patients. They have held this contract since 2007.

The clinic operates from the ground floor of a building. The ground floor has a reception area, main waiting room and six clinical areas including a theatre and laser treatment room. On the first floor, there is a managers' office.

The service has not been subject to any external review or investigation by the CQC at any time during the 12 months before the inspection. There had been no never events in the preceding 12 months. Never events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been put into place by healthcare providers.

We inspected the service using our comprehensive inspection methodology. We carried out an unannounced inspection on 7 October 2022.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/

how-we-do-our-job/what-we-do-inspection.

We rated it as inadequate because:

- Following this inspection, we served the provider Warning Notices under Section 29 of the Health and Social Care Act 2008. The warning notices told the provider they were in breach of Regulations 12 and 17 and gave the provider a timescale to make improvements to achieve compliance. The principles we use when rating providers requires CQC to reflect enforcement action in our ratings. The warning notices identified concerns in the safe and well-led domain. This means that the warning notices we served has limited the rating for safe and well-led to inadequate. The warning notices that we issued have not been published.
- Equipment checks were not always carried out and recorded to ensure they were ready to use.
- Not all staff had completed safeguarding training in line with guidance and medicines were not stored appropriately.
- Medicines were not stored securely and emergency medicines on the resuscitation trolley were out of date.

Summary of findings

- The service did not have information leaflets available in languages spoken by the patients and local community.
- The service did not have effective governance systems ensuring appropriate recruitment checks to grant staff practicing privileges. There were no systems in place to ensure persons employed had undergone safe recruitment procedures and employment checks.
  - However:

- Staff assessed individual risks for each patient at the initial consultation, using a standardised tool, they reviewed them before the procedure to ensure risks were minimised. Staff obtained consent to care and treatment in line with legislation and guidance.
- Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance. Patients had good outcomes because they received effective care and treatment that met their needs.
- Patients said that staff treated them well and with kindness. Patient feedback included that staff were professional, courteous, compassionate, and patient. The service had received no negative feedback about patient care.
- Facilities and premises were appropriate for the services being delivered. Feedback from patients who used the service and those who were close to them was positive about the way staff treated patients.
- Leaders were visible and accessible to staff. All staff were proud to deliver patient centred care. Leaders had a vision and strategy for the service and all staff knew what this was. Leaders were approachable and responsive to staff feedback.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	My Eye Clinic is an independent provider operated by Minor Ops Limited. The service offers a range of privately funded ophthalmic treatments to patients over the age of 18. Services include general ophthalmology, cataract surgery including pre- and post-operative assessment, Ocular hypertension and glaucoma treatment and monitoring, eyelid and tear duct surgery, YAG laser treatment, medical retina services for conditions that affect the back of the eye. Oculoplastic, medical retina, and yttrium aluminium garnet (YAG) laser treatments. YAG laser capsulotomy is a type of laser treatment that is used to make a hole in the capsule to allow light to pass through to the back of the eye to improve vision. The YAG laser is used as the final part of the cataract surgery. Patients are mostly self-referring and pay for their eye surgery themselves. Surgery days are variable and are booked according to demand. There are no overnight facilities and clinics operate Monday to Friday, with occasional opening on weekends and evenings if there is a need to do so, as required by demand of the patients. They also hold a contract for a community-based ophthalmology service with the local Integrated Care Board for the treatment of NHS patients. They have held this contract since 2007. The clinic operates from the ground floor of a building. The ground floor has a reception area, main waiting room and six clinical areas including a theatre and laser treatment room. On the first floor, there is a managers' office. The service has not been subject to any external review or investigation by the CQC at any time during the 12 months before the inspection. There had been no never events in the preceding 12 months. Never events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been put into place by healthcare providers.

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- Equipment checks were not always carried out and recorded to ensure they were ready to use.
- Not all staff had completed safeguarding training in line with guidance and medicines were not stored appropriately.
- Medicines were not stored securely and emergency medicines on the resuscitation trolley were out of date.
- The service did not have information leaflets available in languages spoken by the patients and local community.
- The service did not have effective governance systems ensuring appropriate recruitment checks to grant staff practicing privileges. There were no systems in place to ensure persons employed had undergone safe recruitment procedures and employment checks.

However:

- Staff assessed individual risks for each patient at the initial consultation, using a standardised tool, they reviewed them before the procedure to ensure risks were minimised. Staff obtained consent to care and treatment in line with legislation and guidance.\
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Summary of findings

- Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance. Patients had good outcomes because they received effective care and treatment that met their needs.
- Patients said that staff treated them well and with kindness. Patient feedback included that staff were professional, courteous, compassionate, and patient. The service had received no negative feedback about patient care.
- Facilities and premises were appropriate for the services being delivered. Feedback from patients who used the service and those who were close to them was positive about the way staff treated patients.
- Leaders were visible and accessible to staff. All staff were proud to deliver patient centred care. Leaders had a vision and strategy for the service and all staff knew what this was. Leaders were approachable and responsive to staff feedback.

Summary of findings

Contents

Summary of this inspection

Background to MY Eye Clinic

The service had never been inspected before. We undertook an unannounced comprehensive inspection on 7 October 2022. There was a registered manager in post at the time of the inspection.

The service is registered to provide:

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

How we carried out this inspection

The team that inspected the service comprised of a CQC lead inspector, a CQC team inspector and a specialist advisor with expertise in ophthalmology. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

We interviewed seven staff including the managing director and registered manager. We spoke with four patients and looked at five full patients care records.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Good	Good	Good	Inadequate	Inadequate
Overall	Inadequate	Good	Good	Good	Inadequate	Inadequate

Inadequate

Surgery

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

Is the service safe?

Inadequate

It is the first time we rated this service. We rated safe as inadequate.

Mandatory training

The service provided and monitored mandatory training in key skills to staff. However, not all staff completed the same relevant training.

Staff we spoke with told us they received a full induction when they started in their roles.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included manual handling, basic life support and infection prevention and control.

Managers monitored mandatory training using a spreadsheet and they alerted staff when they needed to update their training.

The mandatory training matrix provided showed a completion rate of 97% for nursing staff. However, not all nursing staff completed the same modules. For example, some nursing staff completed 22 modules of mandatory training and other completed 25.

30% of nursing staff had expired basic life support and emergency first aid at work training. We were advised that these staff were booked on training courses at the end of the month, however their training had expired in May, June and August 2022.

The mandatory training matrix provided showed a completion rate of 94% compliance rate for medical staff. However, not all medical staff completed the same modules. For example, some medical staff completed 27 modules of mandatory training and other completed 23.

Inadequate

Surgery

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities and dementia.

Safeguarding

Most staff had training on how to recognise and report abuse and they knew how to apply it.

The service had a policy for safeguarding adults and children which included details for how to make a referral or raise a concern.

90% of nursing staff were trained to safeguarding level two for adults and children.

It is understood that the client does not treat patients under the age of 18. However, the providers safeguarding policy details that staff must complete training in Safeguarding children.

All medical staff were trained to safeguarding level two for adults and 90% were trained to level three. 90% had completed safeguarding for children level two and 60% were trained to level three. 10% of medical staff had not completed any safeguarding for children training in line with policy.

The medical director was the safeguarding lead for the service and was trained to level three for safeguarding adults and children, the lead had direct access to someone who was trained to level four and they could be utilised for advice and support if required.

Administration staff had all completed safeguarding level one and 40% had completed level two. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The service had a chaperoning policy which staff knew how to access. There were notices in patient areas advising patients that they were entitled to have a chaperone present for consultations, examinations, and surgery.

The service did not have effective systems and processes in place to ensure safe recruitment, we found omissions and out of date information in relation to recruitment and disclosure and barring service checks.

Consultants did not receive competency-based interviews and no staff had evidence of professional references being obtained prior to starting their roles.

We were unable to confirm that all staff employed by the provider underwent suitable recruitment checks.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Inadequate

Surgery

The theatre scrub area had surgical scrub and masks that were out of date. We asked when the theatre had last been used and we were told that it had been in use within the last couple of weeks, this means staff may have used the out-of-date PPE during this time.

The mandatory training for clinical staff was comprehensive and met the needs of patients and staff. However, administration staff did not complete training in dementia, learning disabilities or mental health awareness.

Disposable privacy curtains are used within the theatre suite reception/ recovery area. The services policy states that these should be changed at least once every six months, sooner if they are soiled. However, the curtains were not dated so it was unclear how long they had been in use.

Staff had access to an up-to-date infection control policy to help control infection risk. Additional protocols were in place in response to the COVID-19 pandemic.

Hand hygiene facilities were available, and masks were available for use if patients chose to do so. All areas were visibly clean and had suitable furnishings which were clean and well-maintained.

The service performed well for cleanliness. Infection prevention and control audit data showed that the service was undertaking regular audits and an external agency had completed an IPC audit the week prior to the inspection with good results.

The service shared with us monthly audits relating to hand hygiene.

Staff followed infection control principles including the use of personal protective equipment (PPE) when required.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff did not always manage clinical waste well. There was no evidence that equipment checks were carried out daily to ensure they were ready to use.

The service had a resuscitation trolley that was locked with tamper proof tagging. Records indicated it had been fully checked and dated and signed on 3 October 2022. However, there were three out of date emergency drugs stored on the trolley that expired in September. This was raised at the time of the inspection, and we received assurances after the inspection that the out-of-date medicines had been replaced.

Staff did not maintain records of daily safety checks of specialist equipment.

Surgery was completed within a standard ophthalmic theatre environment complete with air handling system to minimise spread of airborne infection. Temperature and humidity checks for the theatre were linked to an app on one staff member's phone and there were no records of temperatures in the clinic.

Clinical waste was not always disposed of appropriately and we found clinical waste in the operating area that had not been disposed of.

Treatment rooms had open sharps bins on the floor and windowsills, and some were not dated. An audit shared with us showed that this had been identified as a risk during an internal audit the week before inspection with the need for the bins to be wall mounted identified.

Patient toilet facilities were clean and had appropriate handwash and drying facilities available with a handwashing technique poster visible. The toilets had grabrails and were fully wheelchair accessible, however the emergency pull cord was tied up out of reach.

We saw the cupboard containing substances subject to the Control of Substances Hazardous to Health Regulations was not locked. This meant patients and visitors could potentially access dangerous substances.

The building could be accessed by wheelchair users and was spacious inside. The area was clean, welcoming and had refreshments available.

Warning signs were displayed as required; for example, the procedure room had laser safety signage that was linked to the machines, so they were activated when the machine was in use.

There was a regular maintenance programme in place for specialist equipment.
The service had enough suitable equipment to help them to safely care for patients.
The service had arrangements for testing portable electrical appliances annually.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, daily checks of emergency equipment were not recorded.

The service has a resuscitation policy. The policy stated that daily and weekly checks of the resuscitation trolley should take place. We found gaps in the recording of these checks. Also, it stated there would be periodic audits of the trolley by The Resuscitation Service; however, there was no evidence in the audit schedule of these taking place.

Staff assessed individual risks for each patient at the initial consultation, using a standardised tool, they reviewed them before the procedure to ensure risks were minimised. This helped to ensure only suitable patients were offered treatment at the clinic and the treatment met their individual needs.

Staff used a nationally recognised tool to identify deteriorating patients and knew how to escalate them appropriately.

Deteriorating patients were transferred to hospital via emergency 999 call and all staff that we spoke with confirmed the process for this.

Theatres displayed posters about deteriorating patients and The National Early Warning Score (NEWS2).

Due to the nature of the service, they did not have a sepsis lead. However, staff knew how to identify symptoms of sepsis and if sepsis was suspected the patient would be transferred to a nearby specialist NHS hospital.

Staff used a surgical safety checklist as recommended by the World Health Organisation and Royal College of Ophthalmologists.

Inadequate

Surgery

The service did not have 24-hour access to mental health liaison and specialist mental health support due to the nature of the services offered. However, staff we spoke with demonstrated that they knew how to seek advice from the patients GP and mental health crisis teams if this was required.

Staffing

The service had enough staff to keep patients safe from avoidable harm and to provide the right care and treatment.

The service employed ten nurses, one optometrist and five administration staff which included the registered manager and the practice manager. They had 11 consultants, one of which was also the medical director, and the others were employed under practicing privileges.

Surgeons undertaking laser refractive surgery held the Royal College of Ophthalmology certificate in laser refractive surgery. Surgeons undertaking refractive lens exchange and cataract surgery were on the General Medical Council (GMC) specialist register.

The service did not use agency staff.

The service had good staff retention and no current vacancies.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The service used paper and electronic patient records. Paper records were used for surgery patients and were uploaded to the electronic system. Lid surgery records were electronic. YAG laser treatment records were also electronic.

Cataract surgery notes were paper records, and they are scanned into the electronic system.

We looked at five patient records and found they all were fully completed with evidence of consent, WHO check list and appropriate surgical notes.

Records were legible, contemporaneous and included full medical history, evidence of care plans, decisions made, and care delivered.

The service undertook a variety of record audits including quarterly eye lid surgery, GP letters and monthly treatment record audits.

Patient notes were comprehensive, and all staff could access them easily.
Records were stored securely.

Medicines

Inadequate

Surgery

The service used systems and processes to safely prescribe, administer and record medicines. However, storage was not always secure and fridge temperatures were not monitored effectively.

The service had a medicines management policy. Medicines were stored within the service and two staff were trained to order stock medicines.

There was no evidence of medicine related audits in the previous 12 months.

Medicines were not stored securely within locked cabinets. A medicine storage cupboard had the key in the lock and had sick/fit notes accessible. There were multiple out of date medicines found in the medicine cabinet.

The service had PGDs in place. A patient group direction (PGD) is a written instruction that includes the administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

Staff managed prescribing documents in line with the national guidance.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Eye drops and prep solution were found to be out of date.

Fridge temperatures were monitored intermittently. Logs shared with us for October showed these were not done daily and staff only recorded the current temperature they didn't record the high and low temperatures which would identify if the fridge had gone out of range which could affect some of the items stored in it.

The clinic did not use any cytotoxic medicines or controlled drugs at the time of the inspection.

Emergency medicines were available, and records stated they were regularly checked, however the emergency resus trolley had out of date adrenaline stored on it.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with provider policy.

The service had no never events or serious incidents reported in the last 12 months.

The service had an incident reporting form that staff could access on their internal server.

Inadequate

Surgery

Staff working under practicing privileges received training in duty of candour from their main employer. They understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Meeting minutes showed that incidents and potential incidents were discussed at quarterly clinical governance meetings.

Staff told us they had regular opportunities to meet and discuss improvements to patient care. The service had an up-to-date incident reporting policy.

The registered manager who investigated incidents had received training on the duty of candour.

Is the service effective?

Good

It is the first time we rated this service. We rated effective as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance.

Nutrition and hydration

Due to the nature of the service staff were not required to provide patients with food and drink to meet their needs and improve their health. Patients were not required to fast before surgery and were not without food for long periods. However; the reception area had water, hot drinks and biscuits accessible for patients and visitors.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Patients undergoing ophthalmic surgery were treated under local anaesthesia. They were fully conscious and responsive. Staff did not use a recognised pain tool. However, they were able to monitor the patient's pain throughout the procedure. Staff clearly informed patients about the expected level of pain during and after the surgical procedure. Patients told us they did not feel pain during their procedure, and they felt informed regarding the best way to manage any post-operative pain.

Patient outcomes

Inadequate

Surgery

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The service undertook audits relating to IPC, patient records, service delivery and environment.

The service did not participate in relevant national clinical audits. However,internal audits showed that they compared their results to that of national averages.

The medical director undertook an audit of private cataract surgery to analyse, evaluate visual acuity and refractive outcomes. 98.5% of patients achieved an outcome of best corrected visual acuity of 6/12 or better. This outcome is better than the national average of 94%.

There were no occurrences of surgical complications such as posterior capsule rupture (PCR).

Patient outcomes for Ptosis were monitored over a 46-month period and audited, the results were compared to national averages and showed a success rate of 95.6% with a reoperation rate of 0%.

Staff assessed each patient's medical conditions at the initial stage to decide if the surgery was a suitable choice for them. The service had a low risk of post-procedure infections with no cases reported in the last 12 months.

The service completed a surgical safety checklist audit. The service used the World Health Organisation (WHO) safety checklist developed to decrease errors and adverse events in surgery. The audit showed 95% compliance for completing and uploading the checklists.

Managers and staff used the results to improve patients' outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement overtime.

Managers used information from the audits to improve care and treatment.

The medical director undertook an audit of external Dacryocystorhinostomy (DCR) surgery, which is an area prone to bowstring scar formation. The audit identified a small number of patients with more prominent scarring. It was agreed they would change to a smaller and more rapidly dissolving suture which resulted in a measurable improvement of wound healing, as identified by subsequent audits.

Competent staff

The service did not make sure all staff were competent for their roles. Managers appraised staff's work performance.

Managers told us that competencies of staff were assessed day to day rather than formally and consultants were audited in a cataract surgeon audit.

Registration with professional bodies was checked annually for all staff.

Consultants working under practicing privileges received laser safety training at their main employment in 2021. A refresher of this presentation was also delivered at a MY Eye Clinic clinical governance session in 2022.

One of the consultants employed under practicing privileges was the named laser protection advisor/ supervisor for the service.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Due to the nature of the service, there was little requirement for multidisciplinary meetings to discuss patients. When there was a need for involvement from a general practitioner staff referred patients to an external service as per policy.

Seven-day services

Key services were available routinely Monday to Friday to support timely patient care.

The service was not routinely open seven days a week, however if this was required, they would open the clinic to meet patient need.

Health promotion

Staff gave patients practical support and advice on good eye care.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff knew how to support patients to make informed decisions about their care and treatment. They knew how to follow national guidance to gain patients' consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The service was offered mostly to self-refereeing and self-paying patients; should the patient's capacity to consent be in question staff told us they would refer the patient to a GP for an assessment. However, they could not recall any examples of doing this.

Staff followed guidelines around consent that were based on current legislation and national guidelines. The consent process began with the initial assessment when a patient's treatment options were explained. Patients saw the surgeon to complete the consent procedure on the day of surgery.

Inadequate

Surgery

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. The service undertook monthly audits to check if records indicated individual risks and benefits were discussed and all patients answered.

During the 12 months preceding our inspection, the service had not offered surgery to any patient who was unable to give informed consent to treatment.

All clinical staff had completed training on the Mental Capacity Act, mental health awareness, dementia and learning disabilities.

Staff told us that due to the nature of private practice, patients who attend with their families have already decided to go through the paid private consultation so patients with cognitive impairments wouldn't necessarily self-refer. However,in the unlikely event of this occurring consent 4 would be used. A consent form 4, or treatment in best interests' documentation is used in situations where treatment is being considered for an adult who does not have capacity to consent to the treatment themselves. If it was deemed the patient was then unfit for surgery under local anaesthetic, they would be referred to their GP for referral to an NHS service that would have more suitable facilities and could provide the surgery under general anaesthetic if this was required.

Is the service caring?

Good

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Patients told us that staff took time to interact with patients and those close to them in a respectful and considerate way. They were discreet and responsive when caring for patients.

Patients said staff at the clinic treated them well and with kindness.
Staff followed policy to keep patient care and treatment confidential.

Patient feedback included that staff were professional, courteous, compassionate and patient. The service had received no negative feedback about patient care.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Inadequate

Surgery

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand. Patient information leaflets were available and could be presented in easy read format if this was required.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback.

Is the service responsive?

Good

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so that they met the needs of the local population.

Facilities and premises were appropriate for the services being delivered. Service users could access hot and cold beverages and biscuits in the reception area. Waiting areas and treatment rooms were situated on the ground floor with free parking for service users.

Face to face or over the telephone translation services were available if this was required.

Staff told us that in the event of requiring mental health support for a patient they would contact the patient's GP or use the local urgent mental health support helpline for patients.

Inadequate

Surgery

Managers ensured that patients who did not attend appointments were contacted.

The service had four NHS clinics and patients could refer into the service through an e-booking system.

Meeting people's individual needs

The service did not always take account of patients' individual needs and preferences.

Staff told us they did not routinely treat patients living with mental health, learning disabilities and dementia due to the nature of their service and how patients accessed it. However, they received the necessary training to meet the needs of these patients and all demonstrated how they would manage these patients if needed.

The service did not have information leaflets available in languages spoken by the patients and local community however, managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to treat and discharge patients exceeded patients' expectations.

Referral to treatment times for private patients was around six to eight weeks, except for patients who were having lenses done by a refractive surgeon. The service had taken on the workload of another company who had been booking appointments a long time in advance, they were working hard to get the waiting times shorter for these patients. Referral to treatment times for NHS patients was approximately 14 days.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Managers and staff worked to make sure patients did not stay longer than they needed to on the day of their visit. Managers worked to keep the number of cancelled appointments, treatments and operations to a minimum.

Staff told us that if patients had their appointments cancelled at the last minute, they made sure they were rearranged as soon as possible.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Inadequate

Surgery

There was no complaints information displayed within the service or on their website, however we were told that if a patient wanted to complain they could print off the complaint's information. Following the inspection, the provider told us that they issue service users with patient guides which contain complaints information following their initial consultation.

Information and guidance about how to complain could be made available and accessible to people who use the service. However,It was not available in appropriate languages and formats to meet the needs of the people using the service.

The service had received only one complaint which was relating the storage of boxes in a corridor. This was addressed and the boxes moved.

Staff understood the policy on complaints and knew how to handle them.

Staff told us that a patient had contacted the clinic to ask for more information on the correct use of drops at home. She did not feel the information provided was easy enough to locate. Following consultation with Consultant Ophthalmologist and Ophthalmic Nurse a new 'Patient at home info sheet' was introduced. This information is issued in the 'Patient Information Pack' along with the 'Cataract Surgery Patient Information Leaflet' at the Biometry appointment.

Is the service well-led?

Inadequate

Leadership

Leaders were visible and approachable in the service for patients and staff. However, leaders were not always

aware of the risks, issues and challenges within the service.

Leaders had not identified the risks in relation to out-of-date medicines stored on the resus trolley and in open cabinets despite this being a listed responsibility of the registered manager. There was also no acknowledgement of the risks associated to humidity checks not being recorded.

Leaders did not carry out regular disclosure and barring service (DBS) checks to verify no change in staff circumstances occurred whilst employed by the provider.

We were told the senior leadership team were approachable and visible. They met regularly with each other and communicated directly with staff. Staff told us they found the senior leadership team supportive and were encouraging of development needs.

There was a clear leadership structure from service level to senior management level. The service had named leads for safeguarding, IPC, water safety and decontamination.

Leaders supported staff through supervision and appraisal to identify areas for improvement, progression, and training opportunities.

Staff told us of positive working relationships between management and staff and all felt well supported by leaders. Due to the small size of the clinic, everyone knew each other, and we observed friendly interactions between staff within the clinic.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. Staff were aware of

the provider's vision and how they could turn it into action.

Leaders had a vision and strategy that focused on providing outstanding care. The aim was to offer a first-class service to patients and referrers. The values had patients as the focus and prioritised three objectives: patient safety, excellent care and patient satisfaction.

Staff we spoke with knew what the vision of the service was.

Culture

Staff felt respected, supported, and valued. Staff were focused on the needs of patients receiving care. The

service had an open culture where patients, their families and staff could raise concerns without fear.

Management had created a culture that respected, supported and valued their staff.

Staff were focused on the needs of patients receiving care. Staff felt the local team worked well together and they enjoyed interactions with patients and other team members.

Staff told us that leaders were very approachable, and they would be happy to discuss any needs or concerns. They told us that leaders listened to their suggestions for improving the quality of care. The clinical team have worked together for several years and pride themselves on an excellent working relationship.

Governance

Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, leaders did not always operate effective governance processes.

Staff had regular opportunities to meet, discuss and learn from the performance of the service. We were told that meetings were paused in response to the COVID-19 pandemic, but these had now resumed. When staff couldn't attend meetings face to face, minutes and agendas were shared electronically.

The service had quarterly clinical governance meetings. They discussed complaints and adverse events, numbers of patients treated, clinical audits, safeguarding, mental capacity, and future development plans.

Each quarterly meeting focused on varying topics including a 'policy spotlight' which focused on reiterating the content of policies. Each meeting had standardised agenda and action logs to monitor improvements to the services.

There was no system in place for monitoring documentation supplied during the recruitment process. Not all staff files contained evidence of good character, competence, and experience. We checked the staff files of all staff engaged via practising privileges agreement and we found that some of the required documentation detailed in the practising privileges policy was not available at the time of our inspection. For example, none of these staff files contained evidence of conduct in previous employment via professional references. However, some checks were consistently completed, and evidence retained for staff files. For example, 100% of staff employed via practising privileges had evidence photographic identification, professional registration, and indemnity insurance.

The service did not have effective governance systems ensuring appropriate recruitment checks to grant staff practicing privileges. Practising privileges is the process by which a medical practitioner is granted permission to work in an independent hospital or clinic. To maintain practising privileges, staff had to provide evidence of an annual whole practice appraisal, indemnity cover, an up-to-date Disclosure Barring Service check and evidence of completed training. However, there were gaps in recruitment files with DBS checks not up to date and character references were not obtained.

The senior team did not maintain clear oversight of the competence of staff engaged via practising privileges. The practising privileges policy was not specific to the service. The policy stated that medical practitioners must complete an application form before commencing practicing privileges, however none had done this.

We saw that routine audit and monitoring of key processes took place to monitor performance against patient safety standards and organisational objectives. There was a structured programme of audit covering processes such as infection control, patient records, surgical safety. However, the service did not have audits related to medicines management and equipment. We found multiple out of date medicines and medicines that were not stored appropriately during the inspection.

Management of risk, issues and performance

Leaders did not always identify and escalate relevant risks and issues. Staff contributed to decision-making.

Leaders did not always identify relevant risks or identify actions to reduce their impact. On site leaders gave an example of slippy floors as their main risk. However, they did not identify more immediate risks such as secure storage of harmful substances or out of date medicines.

The service had a local risk register or alternative system that helped to identify and record how leaders mitigated risks. The service had no reported infections, serious incidents, never events or complaints from patients.

The service did not have an effective system for monitoring when disposable curtains in theatres had been hung or needed to be changed.

Leaders did not identify the risk of having the emergency pull cord tied up out of reach in the patient toilet.

An audit undertaken by leaders the week prior to inspection highlighted that treatment rooms had open sharps bins on the floor and windowsills, and some were not dated. The risk was identified and the need for the bins to be wall mounted was identified, but they had not been actioned at the time of the inspection.

There were gaps in the services audits. For example, the resuscitation policy stated that a periodic audit of the resuscitation trolley would be completed by the resuscitation service, however there was no evidence of this taking place. The policy stated that the manager was to maintain oversight of daily trolley checks, records showed gaps in the checking of this and we also found out of date emergency drugs held on the trolley.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

We did not identify any concerns in relation to the security of patient records during the inspection. Paper-based patient notes and staff records were kept securely.

The service had a website where people could access information about the different procedures available.

Staff completed General Data Protection Regulation (GDPR) training as part of their mandatory training. Data shared with us showed that only one member of staff was not up to date with their training.

Staff had access to a web-based portal to gain information relating to policies, procedures, professional guidance, and training.

Staff could access policies, procedures, and clinical guidelines through the provider's electronic systems. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

Engagement

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Managers provided examples of how they had engaged with staff of all grades when making decisions about the service. This included introducing flexible working to offer staff a better work life balance.

The service held a contract for a community-based ophthalmology service with the local Integrated Care Board for the treatment of NHS patients. They have held this contract since 2007.

Clinical governance notes showed that patient feedback was discussed at each meeting. Compliments from patients were shared and there was evidence of investigations of negative feedback.

Inadequate

Surgery

Patients' feedback was invited and was overall positive with comments such as, 'excellent service' and 'staff really put me at ease'.

We saw evidence that meetings cascaded relevant information between management and staff. Meetings were used to discuss clinical governance, risks and audits and were attended by staff, or there was a mechanism in place to share information. Team meetings minute demonstrated discussions about issues that could affect the service such as staffing, equipment and costs.

The service did not undertake staff surveys every year, the most recent results shared with us were from 20

Learning, continuous improvement and innovation

All staff were committed to improving services. They had a good understanding of quality improvement methods and the skills to use them.

The service aimed to provide a complete ophthalmology service. They had two glaucoma consultants, two medical retina consultants, two oculoplastic consultants, two corneal consultants, a vitreoretinal consultant and a medical ophthalmologist.

Consultants treat patients within their sub-specialist area. In addition to cataract surgery, they offered oculoplastic, glaucoma, YAG laser, retinal and refractive surgery.

To support the range of clinical activity the service embarked upon a programme of clinic improvements with a new waiting room, six clinic rooms and a full operating theatre suite. One of the glaucoma surgeons offered the innovative iStent glaucoma drainage implant which was inserted during cataract surgery. One of the corneal surgeons planned to offer collagen cross-linking for patients with keratoconus. Leaders were in talks with three dermatology surgeons to offer Mohs surgery at the clinic for the removal of periocular tumours.

Leaders told us that the service aimed to provide almost all of the range of adult diagnostic procedures and local anaesthetic surgery as would be found in an ophthalmology department in a large teaching 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
Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider must ensure emergency drugs on resuscitation trolleys are in date and ready for use. **Regulation 12** • The provider must ensure Control of Substances Hazardous to Health are stored in line with guidance. **Regulation 12** • The provider must ensure equipment is checked daily and safe to use. **Regulation 12** • The provider must ensure medicines are stored appropriately. **Regulation 12** • The provider must ensure that clinical waste is disposed of in line with guidance. **Regulation 12** • The provider must ensure all staff complete safeguarding training in line with policy. **Regulation 12**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider must implement effective governance systems to ensure persons employed undergo safe recruitment procedures and employment checks. **Regulation 17**