

Optimax Laser Eye Clinics - Reading

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

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Optimax Laser Eye Clinics - Reading is operated by Optimax Clinics Limited.

The clinic has two floors and consists of a main waiting and reception area, a topography room, three consultation rooms, a preparation room, a recovery room and a laser treatment room. All clinical and other patient areas are fully wheelchair accessible.

The service provides laser correction procedures using class 4 and class 3b lasers carried out by ophthalmologists.

We inspected this service using our comprehensive inspection methodology. We carried out the announced inspection on 3 March 2018 and 10 March 2018.

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

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

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

We found the following areas of good practice:

- Patients were involved in their care and had the opportunity to ask questions at all stages of their treatment.
- Staff treated people with kindness and care. The clinic manager maintained consistent local audits and safety and performance monitoring that contributed to the operation of the service.
- There was a culture of open communication and shared learning in the clinic. This included improvements to the service as a result of learning from incidents, near misses and patient feedback.
- There had been significant work nationally in the provider, which was reflected in this clinic, to update and improve policies and protocols. This included establishing policies in line with national standards and best practice guidance.
- Consent procedures were in line with national standards and we saw patients received clear and concise information about their planned treatment and aftercare.
- The local clinic team used a series of audits to assess compliance with the provider's corporate standards. These demonstrated consistently good levels of performance.
- The service was flexible to patients needs and we saw good coordination between surgeons, clinical staff and other clinics in the provider's group to accommodate patient schedules and preferences.
- Local leadership was consistent and resulted in a well-established governance and performance management structure.

However we found the following issues that the service provider needs to improve:

- Clinical staff did not always follow policy in relation to the handling of sterile single-use items. This presented an infection control risk. Procedures in the laser room did not always ensure patients were protected from the risks associated with infection control.

Summary of findings

Following this inspection, we 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.

Amanda Stanford

Deputy Chief Inspector of Hospitals (South East)

Summary of findings

Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|-------------------------------|--------|--|
| Refractive eye surgery | | We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. |

Summary of findings

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Optimax Laser Eye Clinics - Reading

Services we looked at

Refractive eye services.

Summary of this inspection

Background to Optimax Laser Eye Clinics - Reading

Optimax Laser Eye Clinics - Reading is operated by Optimax Clinics Limited. It is a private clinic in Reading. The clinic provides services to patients who refer and pay for themselves.

The clinic had a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are

'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The clinic also offered a monthly lesions, lumps and bumps clinic under consultation with the treating surgeon.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a second CQC inspector and a nurse specialist adviser with expertise in surgery and infection control. The inspection team was overseen by Moira Black, Inspection Manager.

Why we carried out this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory

functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to look at the overall quality of the service.

How we carried out this inspection

The comprehensive announced inspection took place on 03 and 10 March 2018. We gave the service notice of the inspection visit because we needed to make sure appointments were scheduled for our planned dates.

Before our inspection we looked at all of the information we held about the service. This included notifications from the provider. Notifications contain information about certain changes, events and incidents affecting the service or people who use it that providers are required to notify us about.

The provider had completed a Provider Information Return (PIR) in September 2017. The PIR is a form that asks providers to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection visit we spoke with people who used the service. We spoke with the registered manager and staff on duty, including clinicians and the national compliance manager. We looked at treatment plans and care records and looked at the quality assurance systems and feedback from people using the service. We looked at two staff recruitment files, records of staff training and supervisions, records of complaints and incidents and other documents relating to governance and quality assurance. We checked how medicines were managed and carried out a visual inspection of fire safety equipment, escape routes and emergency documentation.

Summary of this inspection

At the end of the inspection we gave feedback to the registered manager. Following our inspection, the registered manager sent us additional information we had asked for.

Information about Optimax Laser Eye Clinics - Reading

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the services first inspection since registration with CQC.

Activity (June 2016 to October 2017)

- In the reporting period there were 315 procedures, all of which required topical anaesthesia
- 100% of patients were self funding.

One clinic manager and one laser assistant worked at the clinic permanently. Surgeons, registered nurses and laser assistants worked for the provider nationally and were rostered to work in this clinic in advance. The surgeons worked substantively for NHS services and provided treatment here under practising privileges.

The clinic has two floors and consists of a main waiting and reception area, a topography room, three consultation rooms, a preparation room, a recovery room and a laser treatment room. All clinical and other patient areas are fully wheelchair accessible.

Track record on safety:

- No never events.
- Five incidents, none with harm.
- No serious injuries.
- Eight complaints.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

We found the following areas of good practice:

- Incidents were investigated and staff understood and adhered to the duty of candour. There was clearly identified learning from incidents and this was communicated to all staff.
- Maintenance and safety procedures for the laser controlled environment were maintained in line with national standards, including in relation to the role and availability of the laser protection advisor and the laser protection supervisor.
- Appropriate systems were in place to ensure staff were up to date with mandatory training.

However we also found the following areas that require improvement:

- Clinical staff did not always follow the provider's policy in relation to the safe and correct use of sterile single-use items.
- Staff did not always adhere to best practice in the laser room in relation to infection control. This related to the decontamination of the treatment bed and the use of disposable face masks.

Are services effective?

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

We found the following areas of good practice:

- The service planned clinical policies in line with the Royal College of Ophthalmologists Standards for Laser Refractive Surgery.
- We found consistent practices in pain management.
- There was a well-defined laser safety leadership structure that included a named supervisor at all times.
- The consent policy reflected 2016 guidance from the Royal College of Ophthalmology in relation to a seven day cooling off period.
- Processes were in place to ensure the competency of the staff team. This included through induction, appraisal and ongoing professional training.

Summary of this inspection

- The clinic manager maintained a system of local audits that ensured care and treatment was in line with national standards and the provider's policies. Where audits indicated areas for improvement the clinic manager demonstrated a proactive approach to implementing them.

Are services caring?

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

We found the following areas of good practice:

- Staff treated patients and their relatives with kindness and respect.
- All members of staff involved patients in decisions about their care and treatment and offered the chance to ask questions for the duration of their care.
- There was a demonstrable focus on involving patients in decisions regarding their care and treatment during all stages. This included the use of 3D animations to demonstrate clinical procedures.
- Staff demonstrated the ability to support patients who experienced anxiety or uncertainty and worked with them to calm their nerves.

Are services responsive?

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

We found the following areas of good practice:

- There was no waiting list for treatment and surgery was offered based on demand.
- The facilities available enabled patients to be treated in a calm and welcoming atmosphere.
- The Medical Advisory Board (MAB) reviewed national and international clinical guidance on laser eye treatment to ensure policies and practice continued to adapt to people's needs.
- The clinic had not cancelled any planned procedures or treatments in the previous 12 months.
- The compliance manager had recently updated care and treatment guidance for patients living with a learning disability, which reflected the clinic's approach to ensuring accessibility.

Summary of this inspection

Are services well-led?

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

We found the following areas of good practice:

- The local leadership structure was well established and staff spoke positively of it.
- Governance systems were well structured and involved staff at all levels of the organisation, including the senior leadership team.
- Staff used quality assurance system outcomes from audits, incidents, complaints and feedback to implement improvements to quality and safety.
- The culture placed value on openness and positive working relationships.

Detailed findings from this inspection

Refractive eye surgery

Safe

Effective

Caring

Responsive

Well-led

Are refractive eye surgery services safe?

Incidents and safety monitoring

- Never events 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. The service reported no never events in the 12 months leading to our inspection and no serious incidents.
- Staff used a corporate reporting system to submit details of incidents and near misses. The clinic manager reviewed and investigated these on an individual basis and discussed them during monthly meetings. This was a centralised system that enabled the provider's central team to track incidents nationally and identify areas for joint learning and improvement.
- Where staff documented an incident that related to a specific patient, they entered details on the electronic notepad attached to each individual's record. This meant any member of staff in the organisation could access details of the incident for the purposes of investigation, audit or planning further treatment.
- An independent safety consultant conducted an annual review of incidents. The clinic manager and their team reviewed the outcomes and learning from this at a team meeting.
- In 2017 the service reported five incidents and 12 near misses. Two incidents related to allegations of property theft, one related to security, one related to the breakdown of a medical device and one incident related to a clinical procedure. Five near misses related to medical devices, two related to clinical procedures, two related to environmental issues and

the remaining three near misses related to staffing, patient ill health and a miscellaneous concern. None of the incidents resulted in patient harm and staff followed organisational policy to maintain patient safety in each instance. We looked at the outcomes for each incident and five of the near misses. In each case we found the clinic team had investigated the issue and disseminated learning or outcomes through staff meetings. For example one incident related to a lens meter fault and the outcome meant staff received a refresher on using backup manuals for topography. One incident occurred when a member of staff entered incorrect data into the electronic records system. They corrected this manually and the person in charge spoke with the patient, carried out a safety review of procedures undertaken and reported the issue to the service desk.

- All of the staff we spoke with demonstrated understanding of the incident reporting procedure and said they felt they received feedback when they had submitted a report. Staff worked in multiple clinics and said they always received feedback and updates regardless of where they happened to be usually based.
- Staff demonstrated awareness of the principles of the duty of candour, including the need to be open and honest when things went wrong. The duty of candour related to national guidance that healthcare professionals be open and honest with patients when something goes wrong.
- There was evidence staff provided patients with a clear and truthful explanation when things went wrong, in line with the principles of the duty of candour. All of the staff we spoke with understood this and could give examples of when they had used it.

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- The clinic manager maintained local records of action taken as a result of national Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts, such as a check of medicine and equipment stocks.
- The clinic manager was trained to safeguarding adults and children level 3, which was a provider requirement. This meant all managers who worked in this clinic had the same level of training, regardless of their usual place of work.

Mandatory training

- Mandatory training included up to 30 modules depending on each individual's role and these were updated annually or every two to three years. Modules included health and safety, infection control and equality and diversity.
- All staff were required to sign their understanding of local laser rules and risk assessments before they were able to work in the laser controlled area. We saw all clinical staff who worked in the clinic had signed this document and the clinic manager maintained a tracking document for when rules or risk guidance changed.
- All staff had up to date basic life support training and registered nurses had immediate life support training.
- The clinic manager maintained a record of the training status of all staff who worked in the clinic, including when their usual substantive base was elsewhere. At the time of our inspection both members of staff permanently based at this clinic were 100% up to date with their training.

Safeguarding

- All staff undertook vulnerable adult and child protection training and the clinic manager was the designated lead for child protection. All staff had up-to-date training to level 2 in safeguarding adults and 50% of staff had completed level 3 training.
- Staff demonstrated good understanding of the principles of safeguarding, including how to access local urgent support and their responsibilities under national regulations.
- The national compliance manager had replaced the previous vulnerable adults policy to a new adult protection policy. This better reflected the responsibility of staff in relation to safeguarding and provided more structured guidance for them in recognising areas of need or concern.

Cleanliness, infection control and hygiene

- The clinic manager was the overall lead for infection control and monitored daily and weekly cleaning and six monthly deep cleans in the laser treatment room. They also audited the standards of cleanliness provided by independent cleaners.
- An infection control nurse carried out unannounced infection control audits to provide additional assurance of the standards of infection control and hygiene, including hand hygiene. The results for the previous six months identified consistently good practice.
- The clinic's water supplies were tested for Legionella annually and staff documented weekly flushing of all taps.
- Infection control standards, practices and training were standardised against National Institute of Health and Care Excellence quality statement 61 in relation to the control of infection. This meant standards were benchmarked against national best practice.
- Registered nurses attended an annual infection control refresher course. This applied to all nurses in the organisation and meant that the nursing team had the same standard of training regardless of which clinic they were scheduled to work in.
- All hand wash basins had liquid soap, antibacterial hand gel and posted World Health Organisation 'saving lives' hand hygiene pictorial guidance.
- In the 12 months leading to our inspection, the service reported three instances of diffuse lamellar keratitis (DLK), which is an inflammation of the cornea. Control factors to minimise the risk were in place and the service manager investigated each instance. This included a review of hand decontamination and a traceability review of disposable equipment used for each procedure. We observed consistently good use of hand hygiene techniques by all staff, including hand washing and the use of alcohol hand gel.

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- Staff adhered to the Association for Perioperative Practice best practice in regards to hazardous waste disposal. For example, there was consistent use of waste streaming with documented monitoring of disposal.
- We observed staff set up a sterile procedure trolley and found they maintained the sterile field.
- The theatre fully complied with the Department of Health Technical Memorandum 60 in relation to the standard ophthalmic operating theatre environment.
- The provider followed the requirements of the Hazardous Waste (England and Wales) Regulations 2005 with regards to waste disposal.
- Staff monitored the humidity and temperature of the laser room and documented this on a daily basis.
- Staff adhered to the standards of the DH Health Technical Memorandum 07-01 in relation to safe standards of waste disposal, including clinical and hazardous waste. For example we saw staff segregated waste in secure, colour-coded bags and maintained a register of the items destroyed.
- The clinic had a service level agreement with a consultant microbiologist who provided advice and training on demand.
- During our observations of clinical procedures we noted staff overall maintained good standards of infection control and hand hygiene. However we saw the nurse did not sterilise or clean the theatre table between patients. We asked the nurse about this who said because a sterile table towel was in place they did not need to clean it between patients. However, this presented a risk of cross-contamination between patients. The infection control policy did not include a standard for how often staff should clean the table.
- We observed the scrub nurse opened sterile eye swabs in advance of needing them and taped them to an item of equipment for rapid access during the procedure. This presented a risk that the items would be contaminated by dust or bacteria, such as from coughing, before they were used. In addition we observed the nurse open sterile packages with non-sterile equipment. Neither of these processes were in line with the provider's single use surgical instruments policy. In addition the clinic manager said

that single-use items were supplied in packages that meant no equipment was needed to open them, which meant staff could easily open them by hand after hand hygiene practices had been followed.

- During our inspection we observed the surgeon wore the same face mask for each patient. Although the provider's policy enabled surgeons to wear masks if they wished, the policy did not explicitly state these should be discarded between patients. This presented an infection risk as it meant patients could be exposed to bacteria that collected in the mask.

Environment and equipment

- The environment was adapted and equipped to keep people safe, including treatment areas with restricted access and separate areas for assessment and recovery.
- The laser protection advisor carried out a risk assessment of the laser controlled environment every three years, or whenever equipment was changed. The most recent risk assessment was completed in November 2015. We saw there were no outstanding actions from this risk assessment and all clinical staff who worked in the service had signed their understanding.
- The clinic manager maintained a maintenance log, which they used to schedule equipment servicing. This included annual portable appliance testing (PAT) for electrical equipment and quarterly checks of laser room pre filters.
- Environmental audits resulted in improvements to standards. For example an audit in 2017 found lime scale build up on some taps, which staff removed and implemented more thorough checking and prevention systems.
- An extended role laser assistant or registered nurse prepared LASEK sponges and completed the related traceability documentation. They also documented tracking information for single-use surgical items.
- The laser room fully complied with Department of Health (DH) Health Building Notes (HBN) 00/09 in relation to infection control in the built environment. The flooring complied with DH HBN 00/10 part A in relation to the design and condition of flooring, which meant it could be easily cleaned.

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- Equipment records were in line with MHRA guidance in relation to laser safety.
- The use and storage of sharps bins met the requirements of the European Council Directive 2010/32/EU in relation to labelling and location.
- Waste bins were appropriate to the environment. For example, they had non-touch pedal operation and closed tops.
- Staff consistently documented temperature checks on the medicines fridge, water temperature and emergency medicines. We saw staff had documented these checks on each day the clinic was open for surgical procedures.
- Staff documented all disposable equipment used during each procedure as part of their traceability records.
- There was a system in place to sign laser room keys in and out of the storage cupboard, which meant there was an appropriate risk management system in place for tracking the keys.
- Staff used disposable surgical instruments for all procedures and documented traceable equipment in patient records.
- The recovery room was equipped with an emergency call button for patients, which was connected to the reception desk.
- Staff adhered to the standards of the DH Health Technical Memorandum 07-01 in relation to safe standards of waste disposal, including clinical and hazardous waste. For example we saw staff segregated waste in secure, colour-coded bags and maintained a register of the items destroyed.
- The clinic manager demonstrated a proactive approach to ensuring the safety of the environment was maintained. For example a fire risk assessment identified that some emergency lights had failed to function in a safety test. The provider's maintenance department had not provided a timeline for the resolution of this issue and the clinic manager had ensured detailed risk management plans were implemented in the interim. In addition the risk assessment found the main exit door opened inwards, which could present a risk for rapid egress. The

manager liaised with the provider's fire advisor who identified the door was safe due to the low occupancy of the clinic and confirmed it was compliant with the Regulatory Reform (Fire Safety) Order 2005.

- Gas cylinders were stored securely and in line with risk assessments.
- A member of the permanent clinic team documented a weekly safety check of electrical appliances to identify any damage or other safety issues.
- An external health and safety consultant carried out fire safety and risk management audits to ensure the clinic complied with national requirements.

Medicines

- The clinic manager was the designated lead for the safe and secure handling of medicines. They carried out audits of prescribing and stock checks to ensure the medicines policy was complied with and had access to an external pharmacist for on-demand support or advice.
- Medicines were stored in line with national and manufacturer guidance, including with restricted access and monitored temperature control.

Clinicians used a prescribing, dispensing and administration of medication policy to safely prescribe medicines and were only permitted to do so if they held current General Medical Council registration. Once a surgeon had prescribed a medicine and applied a drug stamp to the patient's records, the surgeon or an optometrist could dispense or administer it.

We observed staff dispose of cytotoxic eye drops in appropriate hazardous waste bins, which complied with the Control of Substances Hazardous to Health Regulations (2002). Cytotoxic medicines are chemicals that are toxic and must be handled using specific safety processes. Medicines storage processes included safe, secure storage for cytotoxic eye drops and appropriate risk assessments were in place. Staff made people aware of the risks associated with these medicines, including that Mitomycin C was a medicine used off-label from its licensed purpose. Consent

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forms included details of this. The clinic maintained a record of patients who had been administered Mitomycin C as well as a record of disposal and waste collection.

- Staff checked and documented each patient's allergies in their clinical notes and reconfirmed these on the day of the procedure.
- Staff gave patients a prescription information sheet that included detailed administration guidance for each medicine. This included how and when to take each medicine and in what dose.
- We saw staff asked each patient about allergies and documented this in their medical records. Where patients were already prescribed medicine surgeons checked the British National Formulary (BNF) for contraindications and had access to a pharmacist for specific advice.

Records

- A corporate records management policy was in place and the clinic manager audited compliance with this on a quarterly basis.
- The patient records system was electronic and staff at any of the provider's clinics could access patient notes. The system enabled access to records for auditing processes by the compliance team and meant senior clinical staff had immediate access in the event of an incident or complaint.
- Clinicians provided a summary of each patient's care and treatment to their GP if they gave consent.
- The clinic manager audited patient records every three months and documented learning for staff. Most recently this included a reminder to take and record blood pressure for all patients.
- During the three surgical procedures we observed we saw the theatre team completed traceability documentation immediately on use and uploaded this information to the electronic system. In each case staff fully completed the theatre log.
- Hard copy records were stored in a fire-proof facility with controlled access.

Assessing and responding to patient risk

- Staff used the Royal College of Ophthalmologists Standards for Laser Refractive Surgery, the National Institute for Health and Care Excellence (NICE) guidance and the General Medical Council guidance for doctors who use cosmetic interventions when assessing patients for refractive eye surgery.
- We saw the clinical team adhered to the provider's policy for verifying patient identity and planned treatment prior to carrying out a procedure.
- The surgical team used a surgical pause checklist to carry out pre-procedure safety checks on the environment, equipment and staff team. The checklist was based on the World Health Organisation (WHO) surgical safety checklist and we saw staff used it consistently. The clinic manager audited completion of the checklist and between October 2017 and January 2018 found 100% compliance.
- We observed three surgical procedures during our inspection. In each case we saw the team used the WHO checklist fully and appropriately as part of an overall good standard of communication we observed.
- An optometrist carried out a pre-operative assessment a minimum of one-week before a procedure took place in line with National Institute for Health and Care Excellence (NICE) best practice guidance IPG164 and the Interventional Procedures Advisory Committee. This included an eye test and retinal examination to ensure a surgical procedure was likely to be safe.
- Emergency equipment was available in the clinic and included stocks of emergency medicines such as adrenaline as well as oxygen, a biohazard and cytotoxic spill kit, a first aid kit, resuscitation equipment and an automatic defibrillator. All staff had to maintain up to date basic life support training to be able to work in the clinic.
- Although training and equipment was in place to support staff in emergency situations, not all staff demonstrated appropriate knowledge of its use. For example one member of staff was unable to answer questions about basic life support or the use of the epipen although they said they had undertaken training in both.

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- In the event of serious complications, clinical staff arranged for patients to be transferred to an NHS emergency department. The operating surgeon provided each patient with an emergency contact card for use after their procedure. This provided patients with 24-hour access to a clinical advice in case of concerns or adverse symptoms.
- The clinic provided services to patients aged between 18 and 21. Staff used established medical protocols to assess risk and offered refractive eye surgery only if the patient had at least two years' of stable eye prescription.
- The clinic manager carried out a quarterly resuscitation drill. These were unannounced to the staff on duty and the manager monitored response time, how long it took for staff to get assistance and which emergency services they called, which was simulated. The drill also assessed which items of equipment staff brought with them. We looked at the records of the last five resuscitation drills and saw staff performed consistently well, with areas for minor improvement discussed with the clinic manager.
- Staff had identified some patients to be at risk of fainting. To reduce this risk they advised patients to eat and drink before attending their procedure. A fainting protocol was in place that meant patients would remain on the surgical bed with their legs raised until they felt better and the doctor had assessed them.
- Optometrists, who carried out initial assessments, ensured patients were suitable for laser surgery by carrying out a medical history. Where patients have conditions that could increase risk, such as high blood pressure, they required patients to supply a GP approval letter before they could proceed. In addition all patients were required to have a blood pressure reading before they could undergo treatment.
- Staff had updated the discharge process to increase information given to patients about medicines, as a result of previous concerns. For example one patient had misread the instructions given to them and had administered their eye drops orally. This meant the optometrist carried out a final check of each patient's understanding of what they needed to do to reduce risks.

Nursing and medical staffing

- Two ophthalmologists and two optometrists worked in the clinic on a self-employed basis and worked to zero hour contracts. Ophthalmologists provided services under practicing privileges.
- Two full time technicians and two additional clinical staff worked permanently in the clinic.
- The clinic manager maintained a register of checks medical staff to ensure they met the requirements of revalidation and maintained membership of appropriate professional bodies.
- Staff had access to the laser protection advisor through the compliance team at all times the service was in operation. In addition a designated laser protection supervisor was present on each day surgical procedures were carried out.
- The clinic manager used staff competency records and the patient treatment schedule to ensure each shift was staffed by a team with the appropriate skill mix and experience to deliver safe care. The rota was arranged so that an optometrist was always available in the clinic the day after each procedure to provide the first post-operative check-ups.
- A doctor was always on call for the service and provided a 24-hour urgent care advice by telephone.
- All surgeons who provided treatment in the clinic held the Royal College of Ophthalmology certificate in laser refractive surgery and the clinic manager monitored ongoing accreditation for staff who worked in the clinic infrequently.
- Staffing was planned in line with the Royal College of Ophthalmology guidance on staffing in ophthalmic theatres, and the skill mix in line with MHRA guidance on laser safety. There was always a registered nurse present for surgical procedures, which met the best practice standards. There was always a laser protection supervisor on site and staff had telephone access to the laser protection adviser. The service's laser protection adviser worked for another organisation and was available by telephone.
- The provider's central human resources team maintained personnel records in line with legal requirements. The clinic manager maintained local

Refractive eye surgery

records to ensure all staff who worked in the clinic had required documents and checks on file, including photographic ID and an up to date Disclosure Barring Service (DBS) check. In addition, staff were required to maintain up to date immunisation against hepatitis B as a risk reduction strategy for patients.

- Laser assistants and patient advisers were dual role, which meant they were trained to safely carry out the duties and responsibilities of both. This also provided the clinic with greater flexibility as it meant staff deployed from any clinic could cover rota slots.
- A surgeon, a registered nurse acting as a scrub nurse and a laser assistant was present in the laser room for each procedure.

Major incident awareness and training

- Laser equipment had an uninterruptable power supply that staff checked daily. We saw consistent documentation of daily checks as well as documented safety tests in laser engineer reports. Power safety testing was in line with standards set by the Medicines and Healthcare products Regulatory Agency.
- A designated fire warden was in place on each shift and carried out a fire drill every six months. We looked at the results of the last three fire drills and saw staff typically evacuated within 30 – 50 seconds, which met the standard guidance of two minutes.
- We looked at all escape routes and fire exits from the building and saw staff kept them free from clutter.
- A fire folder was kept at main reception and contained information relating to the latest fire and evacuation procedures and risk assessments. This was a quick reference guide for staff in the event of an emergency.

Are refractive eye surgery services effective?

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Evidence-based care and treatment

- Staff had access to all policies and standard operating procedures through the online system.
- A medical advisory board (MAB) was in place for all clinics in the provider's network and set standards for surgeons and optometrists nationally, in line with established guidance. The MAB planned clinical policies in line with the Royal College of Ophthalmologists Standards for Laser Refractive Surgery and the National Institute for Health and Care Excellence (NICE) guidance on photorefractive surgery (IPG164). Policies were readily available to staff and each individual we spoke with demonstrated how they routinely accessed them.
- The permanent clinic team carried out a rolling programme of 16 audits to assess performance against the provider's policies and standards. At the time of our inspection all of the audits were up to date.
- The surgeon verbally counted down from 40 seconds for each use of cytotoxic eye drops and from 20 seconds for the beginning of each laser procedure, which was in line with national guidance.
- Staff used national guidance from the Royal College of Ophthalmology to assess patients' needs and plan their care and treatment. The clinic manager monitored compliance with this through patient records audits.
- The provider had introduced a new version of the World Health Organisation (WHO) surgical safety checklist for surgical procedures that was more tailored to the procedures offered. The clinic team audited use of the checklist and between October 2017 and January 2018 compliance was 100%.
- The laser protection advisor carried out a site visit every three years and re-issued local rules or revalidated the existing rules.
- The provider had an equality and diversity policy that reflected the requirements of the Equality Act (2010) and ensured staff provided services without bias based on people's protected characteristics.
- A central team in the provider audited each surgeon's treatment outcomes using patient clinical records and the outcomes of the patient satisfaction survey.

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- The clinic manager attended monthly meetings to review policies and practices in line with national and international guidance. This was a collaborative meeting with the compliance manager and national clinic managers and meant policies were continually reviewed to ensure they met the latest best practice standards.
- The permanent clinic team maintained an audit trail of updates and changes to local policies and procedures as a tracking tool. This meant staff could easily access the most recent version at any time.
- The national compliance manager had introduced a new training policy for clinical staff that included medical compliance. This ensured compliance with national requirements was standardised across the organisation.

Pain relief

- Staff administered anaesthetic eye drops for pain relief prior to each procedure and asked patients to tell them if they felt any pain. They also carried out a pain assessment during the recovery process and provided pain relief before discharge. This included advice to take over-the-counter pain relief if needed.
- As part of the aftercare programme patients had access to a 24-hour clinical helpline, which included for advice on pain.
- All five patients we asked said they felt staff had explained pain management to them clearly, including the most effective pain relief to take after their procedure. They also said the surgeon had been clear about when they should call the emergency aftercare line when pain exceeded a certain threshold.

Patient outcomes

- Each patient underwent a surgeon-led assessment, medical review and optometrist consultation before being considered for treatment. The lead clinician used the outcomes of each of these stages to identify if the patient was likely to achieve their intended outcomes from treatment.
- The service did not compare its outcomes with refractive error norms in National Institute of Health and Care Excellent (NICE) guidance on photorefractive laser surgery. There was no use of optional audits

suggested by Royal College of Ophthalmologists. However, the provider monitored the patient outcome data for each individual surgeon to establish benchmarks with expected practice.

- The service monitored unplanned patient returns to theatre. In the previous 12 months this had occurred on two occasions. In both cases staff carried out appropriate assessments and additional treatment, including a flap wash for grade 1 diffuse lamellar keratitis. There was no patient harm in either case and the clinic manager presented both at staff meetings to identify opportunities for learning.
- In the 12 months leading to our inspection 21 patients underwent unplanned re-treatment or treatment enhancement. This represented less than 1% of total cases and in each case the operating surgeon and clinic manager carried out a review of care and treatment to identify opportunities for improved practice.
- The service published data on treatment outcomes and included this information in the patient information booklet. This helped patients to decide, along with advice from clinical staff, if their procedure was likely to result in their desired outcome. This included percentages of patients who achieved 20:20 vision after treatment and those who achieved a driving standard of vision.
- Topographical data was collected and stored electronically and the optometrist could access this immediately on completion of the pre-assessment.

Competent staff

- The clinic manager checked and recorded a continuing professional registration check of surgeons with the General Medical Council on a monthly basis.
- New staff entering the service undertook a formal induction. This included study of the provider's policies including health and safety, fire safety, bullying and harassment and equality and diversity. The clinic manager monitored the progress of new staff using practical training competency checklists. We looked at a sample of two completed induction packs and saw they were comprehensive and included a good standard of training and support.

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- The clinic manager maintained oversight of supervisions and appraisals and the clinical lead carried these out with the ophthalmologist team. All staff had undergone an appraisal in the previous 12 months.
- All staff who worked in the laser controlled area had completed Core of Knowledge training and attended a laser protection study day. Staff repeated both of these every two years, which included a practical competence assessment on the safe operation of laser equipment.
- Staff who acted as a laser protection supervisor had attended a certified training course that had been developed specifically for the provider. Laser protection supervisors renewed this training every two years and were required to pass a competency-based exam to enable them to continue practicing.
- Clinic managers and laser assistants were trained to carry out topography and maintained up to date competency checks.
- The compliance manager held a level 4 qualification in teaching and education and doctorate-level training in staff competency training and development. They led the induction programme, which included the emergency and safety elements of mandatory training such as defibrillator use and first aid.
- Staff told us they felt the induction process was structured and supportive and helped them to develop in their role. One member of staff said they had undertaken extended training and supervision when they needed support in achieving a particular competency, which the clinical manager had provided.
- Surgeons held NHS posts in ophthalmic laser treatment care, which meant they maintained up to date understanding of national standards and treatment practice that complemented the provider's training.

Multidisciplinary working

- Staff delivered care and treatment in line with a 'patient journey' protocol that ensured they received continual care from each member of staff involved in their care and treatment.

- Where patients experienced complications after a procedure, staff referred them to the most appropriate specialist service. The clinical team liaised with other professionals where this happened to ensure patients received the most appropriate care.
- Records generated by clinicians were available to staff or other providers if necessary, and care summaries or discharge information was communicated to GPs.

Consent and Mental Capacity Act

- Surgeons led the consenting process, which was completed ahead of the day of surgery when the patient first met the surgeon. There was an additional consent check on the day of the procedure when patients had another opportunity to ask questions.
- The consent process took place a minimum of seven days before the planned procedure, which met the guidance of the Royal College of Ophthalmologists with regards to a cooling off period.
- Staff issued a patient information guide during the initial consultation, which included a copy of the consent form. Patients were told to read this ahead of meeting the surgeon and to highlight any areas they did not understand or wanted more clarification on.
- Staff were trained in the Mental Capacity Act (2005) as part of their privacy and dignity training, which they used to establish if a patient had the mental capacity to make their own decisions.
- The compliance manager had recently updated the consent policy to improve clarity and to ensure it was fully embedded in the provider's 'patient journey' service plan.

Are refractive eye surgery services caring?

Compassionate care

- During all of our observations staff spoke to patients and their escorts with kindness and compassion. For example we saw reception staff warmly welcomed patients who presented in the clinic and

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demonstrated a friendly, professional manner when speaking on the telephone. We saw staff readily provided reassurance and guidance where patients experienced anxiety or nervousness.

- The clinic manager monitored standards of care against the provider's service delivery policies and had facilitated a culture in which staff viewed each patient as a unique individual with different levels of need, understanding and worries about treatment.
- Staff demonstrated attention to detail when providing a caring service. For example each member of staff asked how the patient preferred to be addressed and adjusted to a formal or informal communication approach based on personal preferences. During our observation of an optometrist-led consultation we saw the member of staff adjusted to a patient's shyness and built a rapport by developing an understanding of the reasons the patient was interested in laser surgery.
- Staff asked patients to complete a satisfaction survey after their treatment and the team used this feedback to identify areas of good practice and for improvement. The clinic manager monitored feedback during the calendar year and presented a summary in an annual patient's guidebook, which was made available in the clinic. During the pre-surgical process staff took the time to ask patients about any specific personal, cultural or social needs they had in relation to their treatment.
- After each procedure staff took time to ask the patient how they felt and assess any discomfort or anxiety. They provided refreshments and pain relief and took the time to answer questions and provide reassurance.
- Staff were trained to provide a positive and compassionate aftercare experience, such as by asking each patient how they had slept and felt their first night after treatment.
- The provider's privacy and dignity policy had recently been updated and included guidance for staff on tailoring care to patients with conditions such as reduced mental capacity or a learning difficulty.

- We saw staff respected each patient's privacy by closing doors to consultation rooms, speaking discreetly in the waiting room and at the reception desk.
- Staff had displayed anonymised thank you cards and letters in the waiting area.

Understanding and involvement of patients and those close to them

- The provider had a counselling team trained to discuss care with prospective patients. This team ensured patients understood all aspects of their care as well as the planned outcomes and risks of complications.
- Staff provided patients with printed information that explained their planned treatment, likely results and aftercare instructions. All of this information was discussed verbally during assessments and before and after treatment and the printed copy was for reference purposes, rather than to provide new information.
- We saw all patients were supported to understand treatment options, including risks, benefits and potential consequences, as per the National Institute of Health and Care Excellence Quality Standard 15 statement 5, and Royal College of Ophthalmologists professional standards for refractive surgery.
- The service encouraged prospective patients to read the satisfaction reviews of those who had undergone treatment previously by presenting survey results and comments in the clinic and on the service's website.
- Processes were in place to ensure patients always had access to information about their treatment plan, including guidance on how they could obtain more information when they wanted it. Staff carried out a courtesy call to each patient two weeks prior to their consultation to plan their visit and answer any final questions. This proactive approach to communication was reflected throughout all stages of the patient journey, from first enquiry to long-term aftercare.
- We observed one patient during their initial pre-assessment, which included topography and a consultation with the optometrist. We saw the laser assistant and the optometrist explained each step of the process to the patient and offered them frequent opportunities to ask questions. They explained what

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would happen during the procedure to reduce anxiety, such as explaining when and why they would feel puffs of air in their eye. Both members of staff used good humour with the patient, who was nervous, and said they could ask for a break at any time if they felt uncomfortable.

- Staff used 3D animation technology to demonstrate to patients how the laser treatment worked in their eye and how it altered their vision. They also used this system to show other aspects of the procedure, including how eye flaps were created. This encouraged patients to ask questions and helped them understand more about their procedure.
- Staff provided patients with printed and verbal information on the risks of their treatment, which included easy to understand quantifiable information. For example we saw one member of staff explained the risk of infection after the procedure as one in 3000, which they said was 14 times lower than the risk of infection with contact lenses. They also said they had a risk of experiencing dry eyes for up to three months and a 1% chance of experiencing this long-term. We saw this method of communicating risk was effective and the patient told us they found it a helpful way for them to make a decision. We asked five other patients about their experience of discussions with staff to help them understand their procedure, their treatment options and the risks involved. In each case we were told they felt well-informed by staff who they felt had been open and honest with them. We saw staff were open and honest with patients about the future efficacy of their planned treatment before they consented. This meant patients were given the opportunity to weigh up their choices and make the best decision for them. For example we saw one member of staff tell a patient there was a 2% chance they would revert to their pre-operative glasses prescription in the future and they would be offered a top-up surgical procedure if this was safe.

Emotional support

- Throughout all of the procedures, we observed staff reassured patients before, during and afterward their procedure. This included gentle encouragement during the laser procedure to remain calm and still, and reassurance while they were recovering in the darkened recovery room.

- We saw staff facilitated a relaxed and friendly environment in the waiting area and recovery area and made themselves readily available to answer questions.
- We saw all members of staff had natural empathy and a warm, friendly nature that helped patients to relax. For example when one patient was embarrassed to talk about their occupation we saw the optometrist skilfully reduced the patient's discomfort and built trust with a friendly and informal discussion. In addition where a patient became nervous at having eye drops administered, the optometrist used techniques to help reduce anxiety such as helping them focus on measured breathing.
- A patient advisor provided counselling at the pre-operative assessment stage. This included issuing a printed patient information guide and we saw the member of staff marked the pages most relevant to the individual. The guide included aftercare information about activities such as swimming and flying.
- Staff offered patients the opportunity to have a simulated ('dummy') procedure when they were nervous or worried about their procedure. We spoke with one patient who had taken part in a simulated procedure and told us, "[The team] were reassuring and encouraging throughout. I wouldn't have gone ahead with it if they'd been anything less than understanding and they were much better than my expectations."

Are refractive eye surgery services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- Patients accessed the service by making an appointment on the provider's website or by telephone and services could be provided from multiple clinics for the same patient. The clinic did not provide NHS services.
- Staff delivered treatment to patients regardless of whether they lived in the local area and the decision to

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treat was made after excluding conditions that could affect safety or outcomes. For example the service did not treat people under 18 years' old, pregnant women or those who were breastfeeding.

- The Medical Advisory Board (MAB) reviewed national and international clinical guidance on laser eye treatment to ensure policies and practice continued to adapt to people's needs. For example at the annual MAB meeting in 2017 the board identified that treatment could be provided for patients living with multiple sclerosis or type 1 diabetes if certain conditions were met.
- All procedures were carried out in line with Royal College of Ophthalmology professional standards. This meant if another surgeon than the individual planned carried out a patient's procedure, they used the same standards.
- A laser failure policy was in place that instructed staff not to turn away any patients in the event of an equipment failure until they were assessed by the surgeon. Surgeons and on-call engineers liaised with each other to plan service delivery in the event of disruption so that support staff could reschedule treatment on a different date or at a different clinic.
- Although treatment was planned based on the patient's needs and their location, we saw staff offered them the opportunity to choose their particular surgeon. This included providing printed information sheets about the experience of each surgeon and whether a specific choice might mean they need to attend another clinic.

Access and flow

- All patients self-referred to the service and the clinic offered elective procedures only.
- The provider's central diary team planned treatments up to three months in advance based on the availability of clinical staff and the needs and preferences of patients. This system enabled the clinic manager to plan staffing levels ahead and to identify where they needed to facilitate a Sunday opening.
- Staff used an electronic clinical records system that could be accessed from any branch. These meant patients could move between clinics without the need to repeat tests or scans.

- Services were provided Monday to Saturday from 8am to 6pm and on Sundays on demand. There was no waiting list for procedures at the time of our inspection, and the service demonstrated flexibility to meet patient's needs with regards to appointment times.
- The clinic provided 24-hour, seven day access to aftercare for patients. This included a surgeon-led telephone advice line that could be used to discuss symptoms or concerns. Patients could return to any of the provider's clinics for advice or review by an optometrist or surgeon after their procedure.
- The clinic manager on the day contacted patients who did not attend a booked appointment and helped them to reschedule.
- Staff adjusted time spent in the recovery room to each patient's needs. This was based on clinical need and input from the patient, who was only discharged when they felt comfortable.
- The clinic had not cancelled any planned procedures or treatments in the previous 12 months.
- We spoke with a patient who was attending for a procedure having been initially seen at another clinic some distance away. They told us they had been able to attend different clinics based on their schedule and availability and had found the flexibility of staff to be a key deciding factor in their use of the service.

Meeting people's individual needs

- All patient areas were wheelchair accessible and adaptations had been made to improve access, including toilets equipped with handrails. Where another clinic in the provider's network had been unable to safely treat a person because they lacked suitable access, the provider funded transport to this clinic so patients would benefit from the environmental modifications.
- Patients received continuing care under a lifetime care guarantee. This meant they were assured of ongoing aftercare to address concerns or future complications.
- Surgeons tailored treatment to each patient's needs based on the results of their pre-assessment that established the extent of their refractive error and the level of correction required. For example staff offered both monovision and multifocal lens implant treatments.
- The compliance manager had recently updated care and treatment guidance for patients living with a learning disability. This ensured their needs could be

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met safely by the clinic and provided guidance for staff on establishing consent and any communication needs.

The policy was based on quality standards guidance from the Royal College of Ophthalmology for eye treatment for adults living with a learning disability.

- During our observations of an optometrist consultation we saw the service and treatment options were individually tailored to patient needs. For example a patient told the optometrist they experienced a specific type of visual disturbance when driving at night. The member of staff discussed this with the patient in depth to ensure the service could realistically meet their expectations as well as safely provide treatment.
- Patients were required to attend a series of four follow-up appointments after their procedure. Staff explained this requirement during the preoperative assessment and it was included in the signed consent form. Patients were also required to bring non-prescription sunglasses with them and have an escort with them on the day of the procedure.
- An emergency after care cover policy was in place and ensured patients would be seen, free of charge, for urgent retreatment under specific circumstances.
- We saw evidence of a high standard of working relationships between different clinics in the provider's network to meet individual needs. For example one patient had undergone treatment at the Reading clinic and then presented at another clinic after getting dirt in their eye. This clinic was not equipped to provide an emergency flap lift and the manager liaised with the Reading clinic to stay open late to enable the patient to be seen.
- Translation and interpretation services could be sourced for patients under the provider's recently updated interpreting and translation policy. Patients were required to pay for this service as it was provided by an external agency and staff could plan for this in advance.

Learning from complaints and concerns

- There was a formal complaints policy in place. This was readily available in the clinic and on the provider's website. Patients also received this information in printed information with their aftercare pack. The provider's complaints administrator and medical compliance manager provided additional oversight and support, to both patients and the clinic team.

- All staff were trained to resolve minor issues and complaints as soon as they were raised verbally in the clinic and to escalate these to the clinic manager if they were unable to resolve them.
- The provider told us they would refer patients who felt their complaint had not been resolved to the CQC. However CQC does not engage with individual complaints and instead the clinic should have directed patients to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS). We spoke with the compliance manager about this who noted ISCAS was available on a membership-only basis and therefore they would refer complaints to the General Medical Council or a regulatory body.
- Between October 2016 and December 2017 the clinic received eight complaints, of which five related to treatment results and three related to the service. We saw from the response to each complaint that the clinic manager and complaints administrator investigated each case, apologised if appropriate and offered a resolution. For example one patient was concerned they needed additional treatment and that the service had not contacted their GP. However staff identified the patient had not provided consent for this and the manager had tried contacting them to explain.
- We saw the Medical Advisory Board reviewed trends in complaints during their annual meeting. For example in 2017 the board identified a trend of patients who complained about the results of their surgery whose medical records showed they had achieved the clinical goal. To address this, the board reviewed how optometrists met patient expectations at the point of consultation to ensure they understood the likely outcomes.
- The clinic manager kept a verbal complaints and feedback log so that information could be captured when patients did not want to make a formal written complaint. For example one patient commented they felt the surgeon had rushed them into treatment. The clinic manager spoke with the person and met with the surgeon to discuss and resolve the issue, which had been a misunderstanding.

Are refractive eye surgery services well-led?

Leadership and culture of service

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- A clinic manager was based permanently at the location and led the clinic on a day to day basis. Where the manager was unavailable a clinic manager from another location provided cover, which meant there was always a senior presence on site.
- The clinic manager told us the medical advisory board (MAB) was accessible as a group and provided clinical leadership and guidance, which contributed to learning and continual improvement.
- There was a demonstrable culture of openness in the clinic, including with patients and staff. For example the service published treatment outcome data and risk information openly and clinic managers had training in the duty of candour. We also saw pricing for treatment was presented simply and staff ensured patients understood all costs, including those associated with potential future treatment needs, before proceeding with surgery.
- Six patients we spoke with commented on the open and transparent communication they had experienced from staff. This included transparent and clear pricing and medical information.
- Leadership staff from different areas of the business demonstrated consistent communication with each other. For example monthly compliance meetings included the chief executive officer, the director of operations, infection control nurses, the head of human resources and the medical compliance officer.
- All of the staff we spoke with were positive about the leadership structure and their relationship with the senior team. For example staff told us the chief executive, director of operations; the director of human resources and the compliance manager were approachable and supportive. Staff said they appreciated being able to meet the senior team during their induction

Vision and strategy

- The provider had a corporate-level vision in place, which all clinics were required to follow. The senior management team were responsible for ensuring staff delivered care and treatment in line with the vision and strategy, which was based on patient demands and market trends.
- The service displayed the statement of purpose for patients in the waiting area.

Governance, risk management and quality measurement

- A national compliance manager, who reported to the director of operations, led overall governance and quality control. They also led two regional infection control nurses in clinical governance.
- A provider clinical governance and risk management policy was in place and readily available to staff in the clinic. Where risk had been identified, the clinic team had implemented controlling factors that were made readily available to staff. For example one risk related to administration staff working in the building alone. Where this occurred access to the building was controlled and a buddy clinic was identified, which the administrator contacted at agreed times.
- The clinic manager, with support from the compliance manager and provider's central team, monitored service performance using key performance indicators that were set centrally for all clinics. Patient feedback through satisfaction surveys, market share, income and reputation formed the overarching framework for the senior team to assess quality.
- A national compliance manager was the location lead for governance and quality monitoring.
- The clinic manager ensured all clinical staff working under practicing privileges had appropriate professional indemnity insurance and this process was overseen nationally by the MAB.
- The clinic manager used a risk register to monitor risks to the service on a quarterly basis and to track improvements and risk reduction strategies. At the time of our inspection there were 37 active risks and we saw the clinic manager reviewed the register on a quarterly basis. We reviewed the most recent risk register available and found staff actively used this to deliver safer care. For example the service provided adjustable seating and tables in the topography room to reduce the risk of back injury to staff and the manager monitored a key signature log to control access to restricted areas. None of the current risks presented an immediate or significant risk to patients or the delivery of care.
- Risks relating to equipment were clearly identified and managed. This included the risk of a fluorine gas leak, which is poisonous if inhaled. In such an incident an audible alarm would sound and staff would follow a specific emergency action protocol.

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- A separate risk assessment, carried out by the laser protection advisor, was in place for the laser treatment room and the operation of the laser. This was due to be reviewed in November 2018 and the clinic manager monitored it in case it needed an earlier update.
- The national compliance manager led a monthly compliance meeting with clinic managers following feedback that staff would benefit from more involvement in governance processes. We reviewed the minutes of two meetings from 2017 and saw they were focused on clinical governance, safety and quality assurance. There was evidence of continual improvement from the meetings, including learning from feedback and changes to medication guidance.
- Senior managers from each of the provider's core departments met monthly to review quality performance, patient outcomes and risks to the organisation. We looked at the minutes of four meetings in 2017 and found developments and improvements to the service were evident in each and that each department tracked improvements and risks as part of the overall governance structure.
- Radiation safety was a key part of the clinic's risk management and included an up to date radiation safety policy updated within the previous 12 months.
- The surgical services manager and managing director met weekly as part of the clinical governance process. Staff demonstrated understanding of how to refer to colleagues elsewhere when needed, such as for support in answering patient's questions or resolving customer service queries.
- Surgeons were required to hold professional indemnity insurance, which the provider checked monthly.
- Although the service was always planned to manage risks within the clinic, staff had access to the provider's head optometrist and clinical staff in other locations if additional support or expertise was needed. Good working relationships between clinics were well established and we saw evidence of regular communication for problem-solving and support.
- Staff handled patient records and personal information in line with the provider's corporate information management and data protection policy. This ensured patients understood how the organisation used and stored their data and their rights of access to it.
- The provider had a networked electronic system that meant staff at any clinic could access patient notes. This enabled staff to attach additional notes and assessments to each patient's records regardless of where they presented for treatment or aftercare.
- The operating surgeon provided each patient with a post-procedure summary that detailed the treatment they had undergone along with post-operative medication prescribed and aftercare details. Surgeons requested consent to contact patient's GPs during the pre-assessment stage and would send a copy of this letter to them if the patient had consented.
- Staff documented unplanned outcomes, such as a return to theatre or treatment enhancement, in patient's records. Where someone other than the treating surgeon documented this, the surgeon who delivered the initial treatment was notified automatically by the electronic system. This meant the treating surgeon and clinic manager maintained ownership of the patient's treatment plan and enabled them to work with other staff involved to review and audit treatment and outcomes.

Public and staff engagement

- The clinic team were proactive in engaging with patients and obtaining feedback to improve the service and to promote staff morale. For example the clinic manager presented compliments at staff meetings and used these to acknowledge the work of their team. Similarly, where feedback indicated a need for improvement, the team demonstrated how they explored this. A recent change occurred following feedback from patients that they had not expected to spend as much time in the clinic on the day of treatment. In response the clinic manager discussed this with the team, who ensured communication with patients included a discussion of realistic timescales for the day of treatment. The reception team ensured they kept patients up to date with waiting times, including immediate notification of delays.
- The surgical services manager told us staff frequently visited different clinics within the provider's group to identify learning and good practice for their usual place

Managing information

- Electronic tests and eye scans were held on the provider's centralised system. This meant records were available to all surgeons providing services, regardless of location.

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of work. However, staff we spoke with said they were not aware this happened, and said they felt working between clinics was solely due to demand or short staffing.

- Surgeons and the senior clinic and organisational team joined a conference call with the Medical Advisory Board (MAB) four times annually to discuss changes in practice and policies. This reflected a new structure to increase

meeting frequency and involve more members of staff critical to the success and safety of the business. The clinic manager led a discussion about the latest patient feedback and trends at each team meeting.

Innovation, improvement and sustainability

- A corporate closure strategy was in place, which would transfer patient aftercare to another provider in the event the business stopped trading.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Ensure that clinical staff follow infection control policies and best practice guidance in relation to the handling and use of sterile single-use items.
- Review the guidance for the use of face masks by surgeons to minimise infection control risks.
- Review the guidance for clinical staff in relation to the decontamination of the theatre bed between patient procedures.
- Ensure staff trained in the use of epipens and in basic life support have their knowledge and skills maintained.