

Accuvision Limited

Accuvision Eye Care Clinic - London

Inspection report

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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

Good



Are services safe?

Requires Improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Overall summary

We rated this service as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risks well. Staff assessed risks to patients, acted on them and kept good care records.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However:

- We found a box of out of date medicines and medicines that had been cut into strips so expiry dates and batch numbers were no longer visible. We also found some medicines were not stored in their original box and were kept in a box with other medicines.

Summary of findings

Our judgements about each of the main services

Service

Refractive eye surgery

Rating

Good



Summary of each main service

Accuvision Eye Care Clinic London is operated by Accuvision Limited. The service opened in 2001 and is an independent private service in Fulham, London. The service provides refractive (laser) eye surgery for patients over the age of 18. The service receives patients from mostly London and the surrounding area.

The service primarily provides customised corneal laser vision correction treatment. The service also provides monovision and presbyopia treatment, and diagnosis and management of keratoconus (a condition in which the eye's cornea is unable to hold its round shape). In addition, the service provides corneal collagen cross-linking (CXL) (the use of ultraviolet light and eye drops in order to strengthen the collagen fibres in the cornea for the treatment of keratoconus). The service also provides visual rehabilitation following CXL, specialist contact lens fitting, treatment for lazy eye (amblyopia) and other minor outpatient ophthalmic procedures under local anaesthesia.

97% of procedures performed in the last year were laser eye surgery and 3% were cornea collagen cross-linking procedures. The service also provides consultations and treatment of young patients aged 12 years and older for corneal collagen cross-linking as part of their keratoconus visual rehabilitation programme. The service does not carry out cataract surgery.

Summary of findings

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Summary of this inspection

Background to Accuvision Eye Care Clinic - London

Accuvision Eye Care Clinic London is operated by Accuvision Limited. The service opened in 2001 and is an independent private service in Fulham, London. The service provides refractive (laser) eye surgery for patients over the age of 18. The service receives patients from mostly London and the surrounding area.

The service primarily provides customised corneal laser vision correction treatment. The service also provides monovision and presbyopia treatment, and diagnosis and management of keratoconus (a condition in which the eye's cornea is unable to hold its round shape). In addition, the service provides corneal collagen cross-linking (CXL) (the use of ultraviolet light and eye drops in order to strengthen the collagen fibres in the cornea for the treatment of keratoconus). The service also provides visual rehabilitation following CXL, specialist contact lens fitting, treatment for lazy eye (amblyopia) and other minor outpatient ophthalmic procedures under local anaesthesia.

97% of procedures performed in the last year were laser eye surgery and 3% were cornea collagen cross-linking procedures. The service also provides consultations and treatment of young patients aged 12 years and older for corneal collagen cross-linking as part of their keratoconus visual rehabilitation programme. The service does not carry out cataract surgery.

The service provides the following regulated activities:

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

All patients are self-referring and pay for their refractive (laser) eye surgery themselves. Surgery days are variable and are booked according to demand. Clinic hours are 9am to 5pm Monday to Saturday, by appointment. Additional emergency late evening and weekend appointments are available on request.

The clinic has a reception area with a main waiting room, administrative office, nurse's office, laser room, topography room, a consultation room next to the laser room and two other consultation rooms.

Our previous inspection of the service took place in December 2017. In 2017, we did not have a legal duty to rate refractive eye surgery services when they were provided as a single speciality service.

We inspected this service using our comprehensive inspection methodology. We carried out our unannounced inspection on 24 May 2022.

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.

Summary of this inspection

How we carried out this inspection

We carried out an unannounced inspection on 24 May 2022 using our comprehensive inspection methodology.

The inspection team comprised a lead CQC inspector, a CQC inspector and a specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection for London.

During the inspection, the inspection team spoke with the registered manager, staff and patients.

We reviewed 10 patient records, personnel files and the clinic's policies.

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>.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **MUST** take to improve:

- The service must ensure that expiry dates on medicines are checked to ensure they are in date and that medicines are stored in their original boxes with clearly identifiable batch numbers and expiry dates.

Action the service **SHOULD** take to improve:

- The service should ensure that audits are fully completed.
- The service should ensure all consulting rooms are free of clutter.
- The service should consider a standalone deteriorating patient policy
- The service should amend the complaints policy to ensure that the CQC's remit is not misrepresented.
- The service should consider recording more detail of the discussions had at governance meetings, so staff are able to easily refer to and understand the minutes at a later date.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Refractive eye surgery	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Refractive eye surgery

Safe	Requires Improvement 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are Refractive eye surgery safe?

Requires Improvement 

We rated safe as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

All staff received and kept up-to-date with their mandatory training. We viewed the training matrix which showed 100% compliance in the training modules.

Mandatory training modules were comprehensive and met the needs of patients and staff. Mandatory training was a mixture of online and face to face training and included modules such as anaphylaxis awareness, consent, awareness of mental health, dementia and learning disability, information governance, infection, prevention and control, manual handling, and safeguarding.

All staff were trained in basic life support. Staff who worked with the laser machines undertook refresher training for the machinery every three years.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service used an online training company which also sent reminders to staff when training was due.

There was a named Laser Protection Advisor (LPA) who reviewed the local rules every two years or more frequently if required. Local rules contain general guidance and instructions necessary to comply with legislation, standards and guidance for the safe use of lasers and/or other light therapy machine systems. Changes made to the local rules would be disseminated to and discussed with staff. Staff had signed to say they had read and understood the local rules.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. They knew how to identify adults and children at risk of, or suffering, significant harm and knew how to escalate their concerns.

Refractive eye surgery

Staff were trained to level 2 and 3 in both children and adult safeguarding and compliance was 100% at the time of our inspection. The registered manager and director of the provider were the safeguarding leads and were trained to level 4. There had been no safeguarding referrals made during the reporting period.

We reviewed the service's safeguarding policy which was in date and detailed the individual responsibilities and processes for reporting and escalation of concerns.

The provider told us they would always double check that patients who were intending to have laser eye surgery were over the age of 18 years by ensuring at the pre-admission stage, patients completed identification verification by providing a copy of their passport or driving license.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinic areas were clean and had suitable furnishings which were clean and well-maintained.

Staff who were trained in the use of the diagnostic equipment were responsible for maintaining and cleaning them after use. We saw that staff cleaned equipment after patient contact.

The service generally performed well for cleanliness and conducted six monthly audits to ensure infection prevention and control procedures were followed, it included hand hygiene audits. We reviewed the infection prevention and control audits which showed 100% compliance however the latest audit in we found that one page of checks on the latest audit had been missed out.

The service had introduced protocols to screen patients for potential symptoms of COVID-19. The waiting area was spacious and allowed visitors to maintain social distancing to minimise the spread of infections.

The provider used single-use surgical instruments which did not require decontamination. The single-use instruments we saw were within their expiry dates.

The laser surgery room had a temperature and humidity monitor within the room to ensure conditions were being maintained consistently within the range for safe operation of equipment specified by the manufacturers of the lasers being used.

Staff worked effectively to prevent and identify post-procedure infections. The provider collected data on post-procedure infections. There were no post-procedure infections in the reporting period.

The service contracted an external company to provide a daily cleaning service.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Refractive eye surgery

Staff told us they carried out calibration checks of specialist equipment before use in addition to the periodic servicing carried out by the external contractor. The provider had contracts with the manufacturers of the specialist equipment at the clinic and we viewed the document which detailed when servicing was due. External contractors could also be called if there was a fault with any piece of equipment.

Medicines cupboards were locked to prevent unauthorised entry.

Consulting rooms and clinic areas were mostly tidy and free of clutter however one consulting room was cluttered with the personal effects of staff.

Services that use laser equipment are required to have a set of laser safety documents, known as local rules, to ensure that staff working with the equipment know how to work correctly within a safe environment and that patients are treated under the equipment and treatment protocols. The service had up to date local rules, and staff supporting with the laser procedure were fully aware of prescribed safety roles. The service had an allocated laser protection supervisor. The service told us they liaised with their external laser protection advisor if there were any adverse events or concerns and advice would be taken on additional actions to be taken.

The door to the laser surgery room was lockable and there was signage and a light above the door which indicated when it was in use.

The service had enough suitable equipment to help them safely care for patients. Electrical equipment in the service had been safety tested.

Waste management was handled appropriately, with different colour coding for general waste, and clinical waste. Waste management and removal including those for contaminated and hazardous waste was in line with national standards. We inspected sharps bins and found them to be correctly labelled and not filled above the maximum fill line. The service had contracted an external company to provide a waste disposal service.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. The service made sure patients knew who to contact to discuss complications or concerns.

Staff assessed individual risks for each patient at the initial consultation, using a standardised tool setting out eligibility criteria and 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 implemented protocols to minimise the risk of COVID-19 infection. A COVID-19 consent form was also given to patients.

Staff had a good awareness and understanding of how to manage a deteriorating patient; they explained they would call emergency services if a patient deteriorated. All staff were trained in basic life support. However, the protocol for managing a deteriorating patient was not outlined within a standalone policy and was within various documentation outlining scenarios such as if a patient fainted or had an allergic reaction. Following the inspection, the provider told us that this aspect was in the process of being reviewed by an external consultant who had been employed to undertake a policy review process.

Refractive eye surgery

Staff used an adapted safety checklist called a minor ops procedure checklist as recommended by the World Health Organisation and Royal College of Ophthalmologists. They also undertook a quarterly audit to review records including the completion of the minor ops procedure checklist. Records we reviewed showed that the checklist had been completed and signed.

Routine follow up appointments were performed either by the treating ophthalmic surgeon or by the optometrist on instruction of the surgeon. If the optometrist had any concerns, they would consult with the surgeon for further advice and review. Patients were also able to see their surgeon on request even if they did not have any clinical concerns.

Patients were given a number to call out of hours and weekends if they experienced any post-procedure complications or if they had any concerns.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels. The service did not use bank or agency staff.

The service had planned staffing levels to keep patients safe. The team was small and did not need the use of a staffing tool to plan staffing numbers. If there were staffing shortage the service was able to use staff from other clinic locations belonging to the provider to ensure patients' appointments were not affected and service was delivered. However, as surgery was elective, the provider was able to reschedule appointments in the event there was a staffing shortage. The service did not employ any agency or bank staff. There had been no sickness or vacancies for staff in the three months prior to the inspection.

Managers made sure new staff had a full induction and understood the service before they carried out allocated tasks. There was a dedicated induction pack for staff to complete before they began working at the service. All staff underwent a three month supervision period when they start at the service followed by an appraisal to discuss progress.

The registered manager worked at the clinic full-time and there was always an optometrist and administrative team on-site during clinic hours. The service also had a registered nurse who was present on days where there were surgical procedures. Ophthalmologists were also on-site two to three times per week and as required depending on the number of appointments booked that week. Ophthalmologists provided services under practising privileges. An optometrist was always available in the clinic the day after surgical procedures to provide the first post-operative check-ups.

The service maintained a register of checks of medical staff to ensure they met the requirements of revalidation and maintained membership of appropriate professional bodies.

There was a designated laser protection supervisor present on each day surgical procedures were carried out. The laser protection advisor visited the clinic every two years to complete a risk assessment. Staff could telephone the laser protection advisor for advice when required.

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.

Patient notes were comprehensive and staff could access them easily. Records were paper based and kept in the administrative office which only authorised staff could access.

Refractive eye surgery

We reviewed 10 sets of patients records and found that they were comprehensive and detailed.

Records contained information from the patient's initial consultation, pre-operative assessments and post-operative notes. Records were comprehensive and included the patient's medical history, medication they took, allergies, whether an interpreter was required, consent documentation, discharge summary instructions. We saw evidence in patient records and that staff completed the surgical safety checks undertaken during laser surgery. We also saw that a COVID-19 questionnaire had been given to patients.

The registered manager audited medical record completion on a quarterly basis and monitored the quality of the records and documentation. The director also undertook random spot checks of records. Audits showed that records were consistently compliant in all areas such as consent form documentation, allergy flags, record of a post-surgery consultation with the ophthalmic surgeon and detail of medication prescribed and given to the patient to take home.

Clinicians provided a summary of each patient's care and treatment to their GP if they gave consent.

Medicines

We found a box of out of date medicines and medicines that had been cut into strips so expiry dates and batch numbers were no longer visible. We also found some medicines were not stored in their original box and were kept in a box with other medicines.

We checked the medicines fridge and found a box of xylocaine 1% with adrenaline which had expired in October 2021. The box was next to other boxes of the same drug which were in date. This was a risk because staff could take out the expired box without realising it was out of date and use it on a patient.

We found in the laser room, a drawer which contained clear plastic bags containing ibuprofen and co-codamol cut up into strips with no expiry dates or batch numbers. It is not good practice to have loose tablets cut from a dispensing pack without batch numbers and expiry dates as there is no way of identifying if they were out of date and there is a risk that out of date medicines could be given to a patient.

We found in the nurse's office, a box of ibuprofen containing a strip of co-codamol in the ibuprofen box. This meant that there was a risk that staff could take the wrong tablet out on the assumption that the box contained only the specified medicine as labelled on the box.

Following the inspection, the provider told us they had taken action by implementing a process by which a second person would complete monthly checks on medicines as well as creating additional storage space for medicines. The provider also implemented a system by which medicines batch numbers and expiry dates were recorded on the patient information sheet within each post operative pack.

Medicines were stored safely in locked cupboards and fridge in the medicines room. Keys were held by the registered nurse and clinic manager. Daily temperature checks of the fridge used to store medicines had been completed. We checked the fridge temperature logs which were all within acceptable range of between two degrees Celsius and eight degrees Celsius.

Medicines used in patients' procedures were clearly listed in the patient records. We saw in patient records that allergies were clearly documented within and on the front of the record.

Refractive eye surgery

Medicines to take away (TTA) were listed within patient notes. The clinic did not utilise or store controlled drugs or cytotoxic drugs. Only staff with the required competencies were prescribing and dispensing medicines. Topical anaesthesia eye drops were prescribed by the ophthalmic surgeon and checked by the registered nurse.

There was one oxygen cylinder which was used for emergencies. We saw that this was stored securely to prevent them from falling. This was in well ventilated areas, away from heat and light sources, in an area that was not used to store any other flammable materials and was in date.

The registered nurse was responsible for the management of medicines at the clinic. The provider had a service level agreement with an external pharmacist for advice on medicines and antibiotic prescribing.

The medicines management policy clearly described obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal of the medicines held at the clinic.

Incidents

Staff recognised and knew how to report incidents. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff we spoke with knew what incidents to report and how to report them. The service had an incident reporting policy and log. The service had not had any incidents in the last 12 months.

Managers told us that any incidents would be investigated and discussed at governance meetings and team meetings. They told us that learning would be shared across the three locations for the provider.

The registered manager reviewed all National Patient Safety Alerts (NPSA) and Medicines and Healthcare products Regulatory Agency (MHRA) alerts. Managers ensured that actions from patient safety alerts were implemented and monitored and updates were disseminated at team meetings.

Staff understood the duty of candour and their responsibilities. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or their relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. There had been no incidents that met the threshold for the duty of candour in the 12 months prior to our inspection.

Are Refractive eye surgery effective?

Good 

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.

Refractive eye surgery

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. At the time of our inspection the service had employed an external consultant to conduct a policy review process to further improve their policy documentation.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

We reviewed policies which were up to date, had review dates and referenced national guidance such as the National Institute of Health and Care Excellence (NICE), the Royal College of Ophthalmologists and Resuscitation Council. Policies were stored on a cloud-based computer system and were accessible to all staff.

The service had a laser protocols folder which contained information on the laser systems, audits, and safety protocol checks.

Patients were supported by staff to understand the various treatment options available to them, including the risks and benefits of the procedures. This was in line with the Royal College of Ophthalmologists professional standards for refractive eye surgery. We observed a consultation between a patient and the optometrist who explained the risks, limitations and potential benefits of the procedure in detail to the patient.

Staff ensured that patients undergoing laser refractive eye surgery had an appropriate pre-operative assessment and opportunity for discussion on their care and treatment. We saw this recorded within patient records and during the consultations we observed on the day of our inspection.

We saw from patient records that patients were given more than one week between treatment recommendation and date of surgery, to allow for time to reflect on their decision to go ahead with the procedure which was in line with Royal College of Ophthalmologists guidance for seven day cooling off period between the initial consent meeting and the final consent by the ophthalmic surgeon.

Patients were given written aftercare instructions and were asked to return the day after a procedure, followed by follow up appointments after one week, three weeks and one month. A 24-hour telephone number was also provided so patients could speak with an optometrist if they had any concerns.

Regular audits were completed for infection prevention and control, hand hygiene, record keeping and laser associated risks. Any issues from audits were shared with staff at monthly team meetings which were minuted.

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 or drink for long periods of time.

Hot and cold drinks were available for patients and their carers in the waiting area.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Refractive eye surgery

Patients were given pain relief after procedures and we saw from patient records that they received pain relief in a timely manner.

Ophthalmic surgeons used local anaesthetic eye drops to ensure the surgery was pain free. Laser eye surgery was a relatively pain free procedure and patients were not expected to experience much discomfort after the procedure.

Staff told us that pain was very mild following treatments. Patients were supplied with anaesthetic eye drops on discharge which were only to be used in the unlikely event pain became unmanageable with over the counter medications. Pain medication used was documented in the patients' records.

Patients were given a follow up appointment the day after their procedure where pain would be discussed. However, the service did not audit pain management.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

The service had limited opportunities to participate in relevant national clinical audits. However managers and staff carried out a comprehensive programme of internal audits and spot checks to monitor improvement over time.

We viewed minutes of the last governance meeting which showed discussion around key performance indicators such as audits, unplanned returns to theatre, healthcare associated infections and significant incidents.

To monitor quality of care and outcomes, the provider looked at the ophthalmic surgeons' key performance indicators annually. Patient outcomes were discussed during surgeons' annual appraisals and these were shared with the director. It included any cases that had unexpected complications, such as post-procedure infections, or those that needed to be re-treated as they did not achieve expected outcomes during the initial treatment.

Patients were also given questionnaires to complete post discharge. The latest questionnaire results were consistently high scores above 90% for questions relating to respect, involvement, safety and staff, clinic environment, consulting optometrist, ophthalmic surgeon, other members of the team, experience during and after treatment.

Staff assessed each patient's medical conditions at the initial stage to decide if the surgery was a suitable choice for them. With laser eye surgery, the possibility remains of a small under or over correction of prescription. If the residual correction was visually significant, an enhancement procedure would be offered by the ophthalmic surgeon when deemed clinically appropriate. Patients were counselled for this possibility at initial consultation and evaluation as well as at the time of consent with the ophthalmic surgeon. The Royal College of Ophthalmologists suggests that most clinics have an enhancement rate varying between 5 and 15%. For all cases treated at the provider in the last 12 months, 0.73% underwent enhancement.

In the last 12 months there were no unplanned returns of a patient to theatre following refractive eye surgery and no cases of infection.

The service measured patient outcomes. Of all patients treated by the provider with laser eye surgery in the last 12 months, 99.9% achieved full visual acuity, 0% complication rate and 0% experienced loss of best corrected visual acuity.

Refractive eye surgery

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The service made sure staff were competent for their roles.

Managers appraised staff's work performance and appraisal rates at the time of our inspection was 100%. Appraisals and validation of professional registration had been completed for all staff within the service. We reviewed some appraisal records which showed discussion around training needs and support around development.

We saw certificates awarded to staff to demonstrate that the laser training had been completed. Staff had signed a statement sheet to demonstrate that they had read and understood the local rules compiled by the laser protection advisor.

We saw up-to-date certificates held by the laser protection supervisor on the safe use of the laser equipment. They were also trained to 'train a trainer' level on the equipment.

We viewed the latest audit of the facility and laser safety protocols by the external laser protection advisor which showed that there were no further action points.

All surgeons who provided treatment in the clinic either held the Royal College of Ophthalmology certificate in laser refractive surgery or have been in refractive surgery practice for a minimum of 10-20 years.

Competencies for ophthalmic surgeons were completed as part of their continuing professional development and was monitored through their appraisal and revalidation via their designated bodies and the GMC. To ensure that surgeons undertook a minimum of 50 hours of continuing professional development activity, the provider required them to submit evidence of this to ensure compliance and retain their practising privileges.

Optometrists were registered with the General Optical Council. All competencies were completed and up-to-date.

There was an induction programme and three month supervision period for new staff to complete prior to starting at the service.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

We saw good multidisciplinary team working between optometrists and ophthalmologists and observed staff liaising in the delivery of patient care. Staff told us communication was good between all staff members including administrative staff.

Staff spoke of good relationships among teams and we saw good team working between clinical and non-clinical groups of staff. Staff were aware of the role of the laser protection advisor (LPA) and knew how to contact them if required.

Patients were encouraged to notify their GP of their procedures and GPs were able to contact the provider should they need.

Refractive eye surgery

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

Patients were reviewed by optometrists at the pre-assessment stage, and by the treating ophthalmic surgeon or optometrist at their follow-up appointment. Patients also met with the ophthalmic surgeon before the day of surgery so they could have an opportunity to ask any questions they had.

Clinic hours were 9am to 5pm Monday to Saturday, by appointment. Additional emergency late evening and weekend appointments were available on request.

Patients were given a 24-hour telephone number to call out of hours if they experienced any issues after their procedure.

Health promotion

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

The service had limited opportunities to be involved in promoting healthy lifestyles.

However, staff assessed each patient's health at the pre-assessment stage to ensure they were suitable for the procedure and empowered patients to manage their own health and to take responsibility for their aftercare treatment. Staff told us they would support patients to be independent by teaching them to administer their own medicines such as eye drops following the procedure. Patients received verbal and written advice on how they could achieve the best outcome during and after the procedure, as recommended in the Royal College of Ophthalmology standards for refractive eye surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance and ensured that patients gave consent in a two-stage process with a cooling off period.

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They understood how and when to assess whether a patient could make decisions about their care. Staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and how to put these into practice.

Patients had time between the procedure recommendation and surgery, a minimum of seven days as advised by the guidance issued by the Royal College of Ophthalmologists. They had two appointments before the procedure where they could discuss any concerns and ask questions related to the surgery.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The service was offered to self-referring and self-pay patients and should the patient's capacity to consent be in question, staff told us they would refer the patient to a GP for an assessment.

We saw that consent was clearly recorded within patients' records. The service undertook quarterly records audits and the director also undertook random spot checks of records. The audits looked at consent and results showed that consent was consistently recorded in patient notes. We saw from records we reviewed that consent had been recorded.

Patients were also asked for consent for the provider to communicate with their GP.

Refractive eye surgery

We were told by staff that they had access to an interpreting service to ensure consent could be obtained from patients who did not speak English although this was rarely used.

Are Refractive eye surgery caring?

Good 

We rated caring as good.

Compassionate care

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

We observed staff taking the time to interact with patients in a respectful and considerate way.

Patients we spoke with told us that staff at the clinic treated them well and with kindness.

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

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Patient questionnaires were overwhelmingly positive. 96% of patients fed back that they strongly agreed staff were respectful of their privacy and dignity. 96% of patients fed back that they strongly agreed that the optometrist put them at ease during their consultation and was professional throughout their appointment. Comments from the questionnaire included: “the care, information and support from the team has been exceptional”; “from start to finish they have been patient, caring and professional with my treatment”; “the surgeon and his team made me feel at ease during the surgery”.

We saw many thank you cards in the waiting area of the clinic. Comments on the cards included: “professional, good service, efficient and would recommend to others”; “excellent surgery”; “friendly staff”.

There were some diagnostic equipment within the waiting room which were used for patients and were quite close to the chairs in the waiting area. This meant that the service could not always maintain patients’ privacy and dignity. However, the provider told us they had not received any complaints from patients about this and any conversation following the tests would only be held in the consultation room. They also told us that some of the pieces of equipment were in the process of being upgraded and would be moved into a consultation room.

Emotional support

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

Refractive eye surgery

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed a consultation where a patient had told the optometrist of how anxious they were about a procedure and they took the time to reassure the patient and ensure they had arranged a family member or close friend to accompany the patient on the day of surgery should the patient wish to proceed.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Chaperones were available on request. Staff told us they always ensured that patients coming in for surgery had someone to accompany them to ensure they could get home safely.

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.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patient feedback questionnaire forms were available in the waiting room of the clinic.

A 24-hour telephone number was given to all patients after a laser procedure. The calls were always answered by an optometrist on call. Information around the laser procedure, aftercare and costs of treatment was available on the provider's website and information pack sent to the patient.

With the patient's consent, chaperones, friends and relatives could be involved in the discussions about treatment and treatment outcomes and post-operative care to support patients in their aftercare.

Staff were aware of patients' anxieties and we observed staff putting patients at ease by explaining a procedure to them and answering questions the patient had.

Patients we spoke with told us that they felt comfortable asking questions. We observed patients being given transparent and accurate information about all the costs involved for the procedure and patients we spoke to told us everything was explained to them clearly.

Are Refractive eye surgery responsive?

Good 

We rated responsive as good.

Service delivery to meet the needs of local people

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

Appointments were booked in advance, at times to suit the patients including evening appointments. The service operated six days a week and laser surgery lists were planned in advance.

The clinic is close public transportation links, making it accessible to patients from a wide geographical area.

Refractive eye surgery

Facilities and premises were appropriate for the services being delivered. There was a waiting area, where hot and cold drinks were available for patients.

The service ensured that all patients received the necessary information and clear explanations of what to expect before the day of surgery. Patient information leaflets were given with instructions on what to do before, during and following treatment.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

The service was inclusive and took account of patients' individual needs and preferences.

The service now had access to an external interpreter service which was available to patients whose first language was not English.

The service provided various ways for patients to give feedback. The service had paper questionnaire forms available in the clinic as well as a QR code that could be scanned with a patient's phone so feedback could be given online. However, patient information leaflets and patient questionnaire papers were available only in English.

The clinic was based on the lower ground floor of a building which was accessible only by a staircase. This meant that patients who had mobility issues, could not access the clinic. Mobility needs would be explored over the phone at the point of booking and if the patient for example used a wheelchair, the service would advise that they would not be able to access this branch of the provider and would offer an appointment at one of their other locations. However given the distance of the other locations, this would not be easily accessible.

Staff understood and respected people's personal, cultural, social and religious needs, and to take these into account. Equality and diversity training was a part of the mandatory training programme.

Ophthalmic surgeons tailored treatment to each patient's needs based on the results of their pre-assessment diagnostic tests.

For younger patients who have had progression of keratoconus confirmed by their consultant, and cross-linking surgery is indicated, parents, carers or guardians were fully involved in the decision making and treatment planning. Patients would be introduced to theatre staff and setting prior to the procedure day and could choose the music they could listen to during treatment. They would have an allocated chaperone and continuity of care would be maintained by ensuring the same staff saw the patient through their treatment journey. In the last five years, the service had seen two young patients aged 14 years and 17 years who required this treatment.

Patients were provided with a lifetime care commitment which involved ongoing long-term care for patients, which was discussed with them from the time of initial consultation. This meant they were assured of ongoing aftercare to address concerns or future complications.

Patients had access to a 24-hour telephone line following their procedure that they could call and speak to an optometrist seven days a week with any concerns or questions they had.

Refractive eye surgery

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 were in line with patients' expectations. A patient we spoke with told us that they had received an appointment for a consultation within a week of making a call to the service.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. Managers worked to keep the number of cancelled appointments and treatments to a minimum. In the last 12 months, there were no unplanned returns to theatre and three procedures had to be rescheduled due to a surgeon testing positive for COVID-19. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible. All surgical procedures were elective which meant that workflow could be planned. Ophthalmic surgeons were allocated theatre times in advance to allow prior planning of laser surgery activity.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. However the complaints policy misrepresented the remit of the CQC.

There were posters in the clinic on how to make a complaint and staff understood the procedures around handling a complaint. Staff told us they would try to resolve concerns as raised and would escalate to the registered manager or director of the service where required.

However, the service's complaints procedure for patients indicated that at stage three, patients can complain directly to the CQC which is not within the CQC's remit. The service did not subscribe to any independent adjudication services that could support investigating complaints objectively when they could not be resolved locally.

The service treated concerns and complaints seriously and showed us an example of an informal complaint which had been fully investigated. The service had not received any formal complaints in the last 12 months.

Are Refractive eye surgery well-led?

Good 

We rated well led as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Day to day leadership was managed by the senior management team on site which included the registered manager, clinic director with support from the two registered managers based at the other two locations.

The senior management team attended monthly governance meeting where incidents, complaints, mandatory training rates were discussed.

Refractive eye surgery

All staff spoke highly of the leadership and told us they were supported by their managers. Medical staff told us the leadership were visible at the service and were approachable.

Vision and Strategy

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

The service aimed to provide high quality and safe patient centred care and treatment with the help of latest technologies and employing “world leading” professionals in refractive surgery.

Managers told us the service continued their ethos of not investing heavily in advertising and relying on new patients being referred to them by other patients.

Staff told us they were in the process of developing a better IT system across the service which would include moving to electronic patient records to better assist staff to provide high quality care to patients.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were passionate about their work and spoke of good teamwork in a patient-centred environment. We found an inclusive and constructive working culture within the clinic among both clinical and non-clinical staff.

We found an open and honest culture and staff told us they felt supported by their managers. They told us the senior management team were visible in the clinic.

Leaders promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Consultants we spoke with told us there was a supportive culture and they felt able to approach the senior management team. An ophthalmic surgeon told us they felt able to discuss with senior leaders if they required new equipment which they felt would further improve patient care.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Staff had regular opportunities to meet, discuss and learn from the performance of the service.

We reviewed the monthly governance meeting minutes which listed discussion points around complaints, incidents, audits, infection control and clinic diaries. However, the minutes listed general points and there was not much detail of the discussion recorded within the minutes, for example the results of audits and actions taken. This meant that if a staff member could not attend, they would not easily be able to understand the context around the topics discussed

We checked a sample of staff personnel files and saw that all relevant documentation, such as professional registration, qualifications and disclosure and barring checks were in place.

Refractive eye surgery

Ophthalmic surgeons worked under practising privileges held the appropriate level of professional indemnity insurance. This was checked annually by the director as part of the practising privileges requirements checklist.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There was a formal audit plan in place which outlined the frequency of the audits and dates of the audits. Audit results were fed back at the monthly governance and team meetings.

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

We reviewed the service's risk register which was in date and covered the potential risks within the service and mitigations in place. Risk assessments had been completed and were up to date and regularly reviewed.

The service had an uninterruptible power supply so laser treatment could continue in the event of a power cut. If there was a fault with the equipment, the provider was able to contact the laser protection advisor by telephone and also the manufacturer of the equipment.

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.

Staff had access to patient records and the results of investigations and tests in a timely manner. The service had paper records which were well organised and stored securely in a locked room accessible only to staff with authorisation.

The service was in the process of considering a transfer to a digital records system for patient records.

There were effective arrangements to ensure the confidentiality of patient identifiable data. Most computer stations we saw were logged out when not in use.

Staff handled patient records and personal information in line with the information governance policy.

Engagement

Leaders and staff actively and openly engaged with patients.

The service used patients' feedback to guide the service delivery and responded to any concerns raised or suggestions made by people who used the service. Patient questionnaire results from the last 12 months were positive and consistently achieved over 90% where patients were happy with the service provided. In the last 12 months, of the 100 respondents, over 90% of patients reported satisfaction in aspects of the service such as respect, involvement, safety, staff, clinic environment, pre-operative and post-operative treatment.

Refractive eye surgery

Staff could give feedback on the service and their individual roles and we saw examples of this within staff appraisal forms. However, the service did not conduct a formal staff survey. Managers told us this was because the staff group was very small.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The service shared their audit and outcome data with the laser manufacturer to contribute to the development and improvement of the technology.

The service also planned to begin long term outcome studies to improve visual rehabilitation of patients with complex corneal conditions.

This section is primarily information for the provider

Requirement notices

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 HSCA (RA) Regulations 2014 Safe care and treatment
Surgical procedures	(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include--
Diagnostic and screening procedures	(g) the proper and safe management of medicines; We checked the medicines fridge and found a box of xylocaine 1% with adrenaline which had expired in October 2021. The box was next to other boxes of the same drug which were in date. We found in the laser room, a drawer which contained clear plastic bags containing ibuprofen and co-codamol cut up into strips with no expiry dates or batch numbers. We found in the nurse's office, a box of ibuprofen containing a strip of co-codamol in the ibuprofen box.