

# Centre for Sight Oxshott

## Quality Report

48 High St  
Oxshott  
Leatherhead  
KT22 0JR  
Tel: 0800 011 2882

Website: [www.centreforsight.com/about-us/locations/sussex-centre](http://www.centreforsight.com/about-us/locations/sussex-centre)

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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

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Outstanding



### 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

Centre for Sight Oxshott is an eye care centre located in Sussex. It was established by the medical director and principal surgeon in 1997.

Centre for Sight Limited operates as a single organisation managed centrally at its East Grinstead location. The Surrey centre in Oxshott undertakes surgical procedures once a month. Oxshott and London centres are open for part of the week and staffed by an administrator at each location. These centres provide local access for patients. Most Centre for Sight staff are based at East Grinstead where all support functions are located. Staff rotate between locations as required with centrally managed rotas.

Centre for Sight Oxshott provides services for adults, children and young people.

The Oxshott centre opened in 2012 and is on the High Street in Oxshott.

The centre is set over two floors and has one theatre and a small outpatients department with two consulting rooms and a reception area.

Services provided include refractive lens exchange, cataract surgery, laser vision correction, corneal grafts, implantable contact lens and intraocular implants.

We inspected this service using our comprehensive inspection methodology. We have reported our inspection findings in the two core services of Surgery and Outpatients. We carried out the announced inspection on 16 October 2017 and an unannounced inspection on 25 October 2017.

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

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

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

### **We rated this centre as good overall. This was because;**

Patients were consistently positive about the care and treatment they received. All patients we spoke with reported staff were kind and caring whilst maintaining their dignity and privacy.

The management team had a good knowledge of how services were provided and were quick to address any shortcomings that were identified. They accepted full responsibility and ownership of the quality of care and treatment within their centre and encouraged their staff to have a similar sense of pride in the centre.

The care delivered was planned and delivered in a way that promoted safety and ensured that people's specific care needs were met.

Medical Advisory Committee (MAC) meetings were undertaken quarterly. MAC meeting minutes showed they were used to discuss improvements to patient care and to ensure care was evidence based.

There was an effective system for identifying and reporting risk. Staff were proactive in identifying risk and near misses.

There was effective incident reporting processes. All staff we spoke with knew how to report and escalate incidents.

# Summary of findings

There were effective infection, prevention and control measures. All areas were visibly clean.

Care and treatment promoted good quality of life and was based on best available evidence.

Patient outcomes exceeded patient expectations.

The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated.

Managers monitored staff competencies annually.

The service had an effective governance framework in place.

There was a positive staff culture with many staff having worked at the centre for a very long time; these core staff offered stability and continuity.

Staff ensured the care and treatment was planned and delivered to meet the needs of patients. Access to the service was seamless and timely.

## **We found areas of outstanding practice in surgery:**

Patients had access to a number of different forms of information, which ensured they were able to make an informed decision regarding treatment.

There were processes and equipment available in theatre in the event of an unexpected complication. Staff practised scenarios involving unexpected complications.

World Health Organisation 'Five Steps to Safer Surgery' checklists in theatre were consistently thorough, with full staff engagement and consultant led.

There was thorough safety checking processes within theatre.

There were effective processes to monitor complications and patient outcomes. Patient outcomes were explained in terms patients could understand.

There was a common focus on improving quality of care and people's experiences.

There were high levels of staff satisfaction across all staff groups. Staff spoke highly of the culture.

## **However, we also found areas for improvement:**

The provider should review guidance on the use of capnography (measuring carbon dioxide) during intravenous sedation.

## **We found the following areas of good practice in relation to outpatient care:**

Ninety-per cent of patient records were electronic which met they could be accessed at any of the three Centre for Sight locations ensuring continuity of care.

Each patient was allocated a coordinator who was the patient's key worker throughout their treatment.

Patients received a thorough assessment of their vision needs, which included hobbies, lifestyle and their post-surgery expectations.

The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care.

## **However, we also found areas for improvement:**

The provider should ensure there is an effective audit trail of prescriptions.

# Summary of findings

The provider should ensure prescriptions are stored securely in line with NHS Protect Security of prescription guidance. Following this inspection, we told the provider that it should make some 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**

# Summary of findings

## Our judgements about each of the main services

### Service

### Surgery

### Rating Summary of each main service

We rated this service as good because it was safe, effective, caring and well-led, and good for being responsive to people's needs.

#### **We found:**

The surgery service had adequate nursing and medical staffing and other staff to meet the needs of patients. There was a holistic approach to assessing, planning and delivering care and treatment.

Innovative and pioneering care and treatment was encouraged and undertaken safely.

The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care.

Staff were proactively supported to acquire new skills and share best practice.

There were high levels of staff satisfaction across all staff groups. Staff spoke highly of the culture.

There was a common focus on improving quality of care and people's experiences.

All staff were actively engaged in activities to monitor and improve quality and outcomes.

Opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued.

High performance was recognised by credible external bodies.

Care and treatment arrangements fully reflect individual circumstances and preferences.

Treatment and care promoted good quality of life and was based on best available evidence.

Patient outcomes exceeded patient expectations.

Policies were evidence based and referenced national guidance. All policies were in date and easily accessible to staff.

Treatment and care was provided in accordance with the National Institute of Health and Care Excellence (NICE) evidence-based national guidelines.

There were systems, processes and standard operating procedures that were reliable and kept patients safe.

Theatres demonstrated effective multidisciplinary working as part of a cohesive team.

**Good**



# Summary of findings

## Outpatients and diagnostic imaging

Good



Decision making about the care and treatment of a patient was clearly documented.

The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated.

The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care.

**However, we found the following areas the service should improve:**

The provider should review guidance on the use of capnography (measuring carbon dioxide) during intravenous sedation.

We rated outpatients as good. This was because the service was safe, effective, caring, responsive and well-led.

**We found:**

The service had effective infection prevention and control processes. All areas within the outpatient areas were visibly clean.

Patient feedback was consistently positive. Patients felt cared for, supported and respected.

Staff greeted all outpatients in a friendly and professional manner.

Patients were able to access the outpatient service in a timely manner.

There were clear processes for handling complaints. Complaints were handled within designated time frames.

There was an effective governance framework in place. There was a comprehensive consent process with supporting information available in a variety of different formats.

Staff reported a positive culture and told us they felt respected and supported by senior management. Staff were highly motivated to provide the best care possible and were proud of where they worked.

**However, we found the following areas the service should improve:**

The provider should ensure there is an effective audit trail of prescriptions.

The provider should ensure prescriptions are stored securely in line with NHS Protect Security of prescription guidance.

# Summary of findings

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Good



# Centre for Sight Oxshott

**Services we looked at**

Surgery and Outpatients and diagnostic imaging



# Summary of this inspection

## Background to Centre for Sight Oxshott

Centre for Sight Oxshott is operated by Centre for Sight Limited. The centre opened in 2012. It is an eye care centre in Oxshott, Surrey. The centre provides services to the local community, nationwide and internationally. All patients are self-funded, self-referring and self-paying for their eye surgery themselves.

Services provided include refractive lens exchange, cataract surgery, laser vision correction, corneal grafts, implantable contact lens and intraocular implants.

The registered manager is the Director of Operations who has been in post since 2013. The accountable officer for controlled drugs (CDAO) was a consultant ophthalmic surgeon.

## Our inspection team

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

## Information about Centre for Sight Oxshott

The centre is registered to provide the following regulated activities:

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

During the inspection, we visited the outpatient department, theatres, pre and post-operative areas and waiting areas. We spoke with more than 10 staff including; registered nurses, reception staff, medical staff, optometrists, operating department practitioners and senior managers. We spoke with three patients and one relative. We also reviewed nine sets of patient records and reviewed a variety of policies and data provided to us.

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

The centre has been inspected twice, and the most recent inspection took place in February 2014, which found that the centre was meeting all standards of quality and safety it was inspected against.

In the reporting period April 2016 to May 2017, there were 308 day case episodes of care recorded at the centre. All of these were privately funded. The most commonly performed procedures were refractive lens exchange (30%) and cataract surgery. During the same time period, the centre recorded there were 803 outpatient attendances. All of these were privately funded.

The provider was unable to split the number of children and young people treated by centre location. Between April 2016 and March 2017, five children aged fifteen years old were seen as outpatients across the three centres. In the same time period, ten 16 to 17 year olds were seen as outpatients. No surgery was performed on children and young people. The only treatment provided for patients under the age of 18 was corneal cross-linking (UV-A light is a surgical treatment for corneal ectasia, bulging of the cornea).

There were nine doctors, three of which were associated with Centre for Sight Limited and six who worked under practising privileges. There were two registered nurses, two operating department practitioners, one optometrist, and administration staff. The centre had its own bank staff.

# Summary of this inspection

## During the period April 2016 and May 2017:

There were 28 clinical incidents across all three Centre for Sight centres. Sixteen occurred in surgery and 12 in outpatients and other services. The provider did not provide incident data by clinic site. However, we reviewed the incident folder which showed which clinic the incident occurred at. This meant the provider was able to monitor where the incidents occurred. Of these incidents, 89% were reported as resulting in no harm, 7% low harm and 4% as moderate harm.

There were no serious injuries reported in the same time period.

There was one non-clinical incident during the reporting period.

There were no reported never events or serious injuries.

There were no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA) or Meticillin-sensitive staphylococcus aureus (MSSA).

The service received 16 complaints across all three Centre for Sight centres. None of these were referred to the Independent Healthcare Sector Complaints Adjudication Service.

## Services accredited by a national body:

A national body does not accredit this service.

## Services provided at the centre under service level agreement:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds Maintenance
- Laser protection service
- Laundry
- Recycling removal
- Radiation Protection Adviser support
- Maintenance of medical equipment
- Water risk assessment
- Air Handling unit maintenance
- Theatre battery back-ups/controls/trolleys maintenance
- Theatre phacoemulsification machines maintenance
- Theatre microscope maintenance
- Laser equipment maintenance
- Information technology hardware and backup maintenance
- Lift maintenance
- Outpatient clinic equipment maintenance
- Air conditioning maintenance
- Building management system maintenance
- Plant room boiler servicing
- Lighting maintenance
- Fire extinguisher maintenance
- Cleaning services
- Human resources support
- Health and Safety Support

# 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?

Good



#### We rated safe as good because:

- The care delivered was planned and delivered in a way that promoted safety and ensured that people's individual care needs were met.
- The World Health Organisation (WHO) checklist was effectively used to ensure safe treatment for patients.
- Laser safety was well managed and records were appropriately maintained.
- Learning from incidents prompted changes to improve the service.
- The environment was visibly clean and hygienic.
- There were processes for ensuring only patients whose needs could be met were treated.
- Staff were aware of their responsibilities with regard to the protection of people in vulnerable circumstances.

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

- The provider should review guidance on the availability of capnography monitoring during sedation.
- The provider should ensure there is an effective audit trail of prescriptions.
- The provider should ensure prescriptions are stored securely in line with NHS Protect Security of prescription guidance.

### Are services effective?

Good



#### We rated effective as good because:

- We found care and treatment reflected current national guidance.
- There was a holistic approach to assessing, planning and delivering care and treatment.
- Innovative and pioneering care and treatment was encouraged and undertaken safely.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care.
- Staff were proactively supported to acquire new skills and share best practice.

# Summary of this inspection

- All staff were actively engaged in activities to monitor and improve quality and outcomes.
- Opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued.
- High performance was recognised by credible external bodies.
- Care and treatment arrangements fully reflect individual circumstances and preferences.
- There were formal systems for collecting comparative data regarding patient outcomes. Patient outcomes resulted in a significant improvement in vision and the ability to undertake day to day activities.
- Staff were up to date with their mandatory training and the majority of staff had received an annual appraisal.
- Care and treatment promoted good quality of life and was based on best available evidence. Technologies are used to support the delivery of high quality care.
- Patient outcomes exceeded patient expectations.
- Policies in use were in date, version controlled, evidence based and reflected current evidence based practice. Policies were accessible to all staff either electronically or in paper format.
- Suitable numbers of competent, trained staff were available.
- Patient feedback was consistently positive about their experience and their outcomes from their surgery.
- Staff ensured that adequate pain relief was provided during surgery. Staff provided patients with further guidance and information regarding pain relief after discharge.
- The staff demonstrated effective multidisciplinary working as part of a team.

## Are services caring?

### We rated caring as good because:

- Patients told us they felt involved in decisions about their care.
- Patient feedback was consistently positive about the approachable, supportive and friendly staff.
- The service ensured that there were processes to maintain the patient's privacy and dignity.
- Patients felt well informed and involved in their procedures and care, including their care after discharge.

Good



## Are services responsive?

### We rated responsive as good because:

- Staff were ready to support patients' individual needs as required.
- Complaints were managed appropriately.
- Managers were driven to provide an efficient service.

Good



# Summary of this inspection

- Waiting times, delays and cancellations were minimal and well managed.

## Are services well-led?

### We rated well-led as outstanding because:

- Staff worked well as a team and were engaged with the local vision, values and strategy to expand and improve the service.
- Effective governance and risk management processes were in place.
- There was a clear leadership and governance structure.
- Surgical outcomes were benchmarked to contribute to continuing improvement.
- The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation is celebrated.
- There was a common focus on improving quality of care and people's experiences.
- The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care.

**Outstanding**



# Detailed findings from this inspection

## 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.

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	 Outstanding	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	 Outstanding	Good
Overall	Good	Good	Good	Good	 Outstanding	Good

# Surgery

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

## Are surgery services safe?

Good 

Safe means the services protect you from abuse and avoidable harm.

We rated safe as **good**.

### Incidents

- Centre for Sight Limited (CfSL) did not report any Never Events in the 12 months prior to our inspection across all three centres. 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.
- In accordance with the Serious Incident Framework 2015, Centre for Sight Oxshott (CfSO) did not report any serious incidents (SIs) which met the reporting criteria set by NHS England in the previous 12 months prior to our inspection.
- Centre for Sight Limited (CfSL) had an Adverse Incident-Near Miss policy, which was in date and reflected national guidelines. The policy set out roles and responsibilities for the investigation and sharing of learning in relation to an incident.
- CfSL reported 28 clinical incidents in the reporting period (April 2016 to March 2017) across all three Centre for Sight locations. Of these incidents, 57% (16 incidents) occurred in surgery and 14% (four incidents) occurred in other services, the remaining 29% occurred in outpatient services (eight incidents). Of these

incidents, 89% were reported as resulting in no harm, 7% low harm and 4% as moderate harm. CfSL report no incidents resulting in severe harm or death. CfSL did not provide incident data to us by location. However, the location of each incident was recorded on the incident log we reviewed, this meant it was possible to know where the incident occurred.

- Incidents were recorded by printing a form off the local intranet, which was then completed by hand and given to the Director of Operations (DoO) who then assigned an individual reference number to the incident. The DoO investigated incidents and had received appropriate training to do this. The medical director provided support and advice in incident investigations if required.
- During our inspection, we found all staff were open, transparent, and fully committed to reporting incidents and near misses.
- During our inspection at CfSO, staff were able to explain how to report incidents and gave examples of when they had reported incidents. Staff said they received feedback from incidents and gave an example of an incident that occurred at one of the other CfSL locations. Staff were able to tell us what changes had been made because of this incident and how their ideas for changes had been listened to and implemented.
- Staff we spoke with were highly committed to ensuring patient safety was optimised and incidents were an opportunity to learn and improve. Staff said that as they were a small organisation they were able to communicate and implement changes quickly. We saw evidence of this when a patient pathway was changed

# Surgery

within a week of an incident occurring. Communication of the change was managed effectively through staff meetings and safety briefings and we saw evidence of this in meeting minutes.

- We saw that discussion of incidents was a standard agenda item on the medical advisory committee (MAC) meeting, team meetings, theatre meetings and clinical meetings; this was confirmed by the meeting minutes.
- Managers told us that when things went wrong with care and treatment, patients were informed of the incident and were given information. This meant they were complying with the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

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

- CfSL produced a clinical quality report quarterly, which summarised performance in key areas, for example; unplanned re-admissions, transfers to other hospitals, complications and infections. This provided an oversight of results and achievements.
- The report was used to monitor improvements in performance over time and to benchmark with other locations in the organisation. The centre collected additional data sets to the minimum recommended by the Royal College of Ophthalmologists in order to monitor performance and risks.

## Cleanliness, infection control and hygiene

- During the reporting period (April 2016 to March 2017) CfSL did not report any surgical site infections at any of the three centres. CfSL rarely undertook bilateral eye surgery on the same day, due to the risk of infection. Instead, patients who were having bilateral surgery had one operation on Monday and the other one on Wednesday. Alternatively, patients could have one operation on Wednesday and the other on Friday.
- We observed all areas of the centre to be visibly clean and tidy. We saw fully completed records of cleaning throughout, for example the theatre had daily cleaning, weekly and monthly cleaning checklists. CfSO carried out regular audits to ensure the recommended

standards of cleanliness in the laser/clinical treatments rooms and theatre environment were maintained in line with the Royal College of Ophthalmologist (RCOphth) professional standards and guidance.

- CfSL had service level agreement (SLA) with an external Infection Prevention and Control (IPC) company who carried out annual training for staff and audited each location. In the last audit in September 2017, CfSO scored 93% compliance (where 85% was classed as satisfactory).
- CfSL had an Infection Control Policy and a Prevention of Surgical Ophthalmic Infection (PoSOI) policy. Both were in date and followed national guidance.
- The PoSOI policy set out the criteria for defining a surgical site infection, risk factors, procedures to minimise the risk of surgical site infection and the process for the management of post-operative infection. This was in line with Royal College of Ophthalmology guidance. September 2017 audit showed CfSO scored 93% compliance.
- The centre used a combination of single use and reusable surgical instruments. Reusable instruments were cleaned and sterilised at the Centre for Sight in East Grinstead.
- There was adequate access to hand gels and handwashing sinks on entry to clinical areas and also at the point of care.
- We saw that furnishings such as counter tops had an integrated anti-microbial varnish on the top. This was to prevent the build-up of bacteria.
- We observed staff used personal protective equipment appropriately, in line with: Health and Safety Executive (2013) Personal protective equipment (PPE): A brief guide. INDG174 (Rev2). London: HSE.
- Monthly hand hygiene observational audits were undertaken and the most recent audit showed 100% compliance. We observed staff washing their hands appropriately in line with the World Health Organisation "Five Moments of Hand Hygiene".



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- We saw theatre staff undertook a competency assessment in asepsis (the exclusion of bacteria and other microorganisms) technique and handwashing techniques, which ensured they had the skills and knowledge necessary to do their jobs safely.
- Staff complied with best practice in relation to uniform standards, theatre dress code and were bare below the elbows (BBE).
- We observed that staff cleaned and disinfected all equipment after each use, for example the theatre trolley, to ensure good standards of hygiene.
- All staff working within the theatre area wore dedicated specialist clothing such as scrub suits, clogs and hats to minimise risk of infection.
- Spillage and cleaning products were available to staff. The centre followed the national patient safety agency (NPSA) colour coding scheme for cleaning materials. This ensured cleaning items were not used in multiple areas, therefore reducing the risk of cross-infection.
- There were systems for the segregation and correct disposal of waste materials such as sharp items. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw two sharps containers were assembled correctly and labelled which ensured traceability.
- CfSL had a SLA with a local NHS trust, which provided microbiology support and advice when required.
- We saw from meeting minutes that infection control and prevention was a standard agenda item for clinical centre meetings.
- We saw the temperature and humidity was checked and recorded at the start of every operating list to ensure it was within the safe range. We saw completed records, which confirmed these checks were undertaken.
- CfSL three centres were ISO 1400 certified and went through an annual process of renewal. ISO 14001 is a set of standards related to environmental management that exists to help organizations (a) minimize how their operations (processes, etc.) negatively affect the environment (b) comply with applicable laws, regulations, and other environmentally oriented requirements; and (c) continually improve in the above.
- We saw that outdated resuscitation guidelines were with the emergency resuscitation equipment. This potentially meant that staff could not follow the most up to date guidelines during an emergency or resuscitation. However, a member of staff with up to date life support skills was always at the centre during procedures.
- CfSL maintained a lens implant traceability register. We reviewed the register. It was complete, with cross-referencing to the patients' medical records. This enabled the recall of lenses should this be required. Patients were given a card to keep which contained the barcodes and unique reference numbers for their own lens implants.
- The theatre had an integrated management system, which ensured airflow was maintained at 15 changes of air per hour, which was in line with the Royal College of Ophthalmologists (RCO) ophthalmic services guidance. The integrated system displayed and alarmed if the ventilation system was not working correctly. The airflow system was tested and serviced annually and we saw service records of its compliance with required standards.
- Each time the laser was used the temperature and calibration was recorded, we saw completed records, which confirmed this. This was in line with RCO guidelines. We saw the humidity and temperature was also documented on the patient's surgical care pathway.
- The Radiation Safety Service at a local NHS trust provided laser protection advisor (LPA) services to the Centre. In accordance with local rules and policies, the LPA undertook checks of the laser equipment.

## Environment and equipment

- Intraocular surgery was performed in a minimal access ophthalmic operating theatre environment, this was in line with Royal College of Ophthalmology guidance. Integrated electronic systems were in place to check the humidity and temperature within the theatre area. This meant that the temperature and humidity levels could be set to ensure consistency. The system sounded an alarm should normal ranges be exceeded to alert staff. It was backed up by a generator in the event of loss of mains power.

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- Local rules were displayed in the laser room and theatre and we saw that staff had signed the register to confirm they had read and understood the local rules. All signatures were up to date. We saw there was a folder, which listed all the authorised laser users. This included photographs of staff and which lasers they were trained to use. Laser keys were kept securely in a locked cupboard and only authorised users knew the lock code.
- There was a laser safety management file in the laser room, it included the laser protection advisor's (LPA's) contact information should it be required. Staff knew the location of the folder to contact if required. The folder was updated annually by the LPA or more frequently if there were changes to staffing or types of laser used.
- The laser protection supervisor was an ophthalmic technician; we saw a certificate of training which showed they had received the necessary skills and knowledge to perform this role.
- We saw laser warning signs were used to clearly identify controlled areas where lasers were in use.
- We checked 10 different medicines and found these to be in date. Medicines had a stock level and were ordered by centre staff and delivered once a week by the courier.
- CfSO had a Home Office licence for the provision of, storage and use of controlled drugs (CDs). Controlled Drugs are medicines liable for misuse that required special management. We saw the CD cupboard was locked, and we checked a random sample of stock levels. We saw the correct quantities in stock according to the controlled drug book and that all were in-date.
- The CD cupboard was located upstairs from the theatre due to legislation, which stipulated what type of wall the CD cupboard must be fixed to. We observed that staff removed a small quantity of CDs from the cupboard at the beginning of the operating list and stored them securely within the theatre. The CDs were signed out of the CD register and stock balances amended, any unused CDs were returned to the CD cupboard and signed back into the CD register. This was done to prevent staff movement between theatre and the CD cupboard upstairs. We reviewed the CD register, which reflected complete records, and stock quantity checks were undertaken by two members of qualified staff.

## Medicines

- CfSL had a medicine management policy, which was in date and was in line with relevant legislation.
- The centre had a service level agreement with a local NHS trust. This covered the provision of medicines management audits. We saw audits of stock, storage and medicines recording were undertaken at a minimum of four monthly intervals. Medicine support was also available from the NHS trust. Some medicines were supplied directly by the manufacturers.
- Medicines in theatre and the laser room were stored securely and there were processes to ensure they remained suitable for use. Fridge temperatures were checked and recorded daily to ensure that certain medicines that required refrigeration remained suitable for use and room temperatures were checked by the centre maintenance staff. Staff were able to explain the procedure to follow if temperatures became out of range.
- CfSO occasionally used cytotoxic medicine (Mitomycin C) which was ordered in advance from the local NHS trust. This medicine can be applied to the eye to prevent scarring. The use of such medicines during eye surgery are 'off label.' Off label medicines are used for a purpose that differs to that stated on the licence.
- We saw CfSL used a separate consent form when patients were going to be given Mitomycin C. This ensured patients were aware that they were receiving an 'off label' medicine and they fully understood the risks and benefits. Patients were also given a copy of the Mitomycin C product information leaflet which gave a more comprehensive explanation of the risks and benefits.
- There was a standard operating procedure (SOP) for Mitomycin C this explained the whole process for the management of the medicine from ordering to disposal. It included the roles and responsibilities, preparation, administration, disposal, and a list of the equipment required. We saw a risk assessment and a Control of Substances Hazardous to Health (COSHH) risk

# Surgery

assessment had been completed. This outlined the risk involved and measures to mitigate the risks and actions to take in the event of an accidental spillage. The centre had a cytotoxic spill kit available, which was in date.

- We saw all medicines were appropriately prescribed by a doctor before administration and this included eye drops.
- We spoke to a healthcare assistant (HCA) who was administering eye drops to patients prior to surgery. The HCA confirmed they had undertaken full training and had to complete a competency before they were permitted to administer the drops unsupervised. The HCA was able to give us examples of possible side effects from eye drops. For example, one specific eye drop could cause a change in blood pressure. Therefore, the HCA explained it was important to take the patient's blood pressure before administering the drops to obtain a base line blood pressure and at regular intervals afterwards.
- We saw the expiry date and batch number of eye drops were documented within the patient's record for traceability in the event of an issue with the drops. The side of the eye to be operated on was written on the eye drops container as a reminder to staff, of which eye to put the drops in.
- We saw patients take home eye drops. The purpose of the medicine, frequency duration and possible side effects were fully explained to them during the discharge. Patients were given a toiletry bag on discharge to store their medicines, which included a patient information leaflet. Staff checked the patient was able to administer the drops themselves or had a friend or relative to support them.
- We saw the pharmacy prescription pad was stored in an unlocked drawer in one of the consulting rooms. This was not in line with NHS Protect Security of prescriptions guidance. All the prescription sheets were numbered. A logbook was available to record the prescription sheet number, date, name of patient and medicine prescribed. We reviewed the logbook and identified one prescription sheet was unaccounted for. We raised this with the Medical Director (lead consultant) and the DoO, who were unable to trace where it had gone. The Medical Director thought they had used it to draw a diagram to explain a procedure to a patient. However, we could not be assured this was the case.
- After our inspection, we were provided with a completed incident form in relation to the missing prescription with actions to prevent a reoccurrence. These actions included keeping the drawer locked and signing them in and out of a locked cupboard at the beginning and end of the day. We were provided with the centre's opening and closing checklist, which included signing the prescription pads in and out of the locked cupboard. When we returned to the centre for an unannounced inspection the drawer in the consultation room was locked. In addition, the prescription would be scanned into the electronic system by the receptionist before leaving the centre to ensure there was an entry in the in the patient's records. This showed that learning from the incident was identified and changes made to minimise the risk of reoccurrence.
- CfSL worked closely with the manufacturers regarding the testing equipment and lasers. Engineers were often on site to oversee and observe equipment in use during theatre sessions. Equipment was regularly serviced and maintained. We reviewed an electronic database of all equipment, which showed the last time it was serviced and checked for electrical safety. This meant equipment was correctly maintained in line with manufacturer guidance and was safe to use.
- There were standard operating procedures (SOP) across the three centres to ensure staff knew, understood and had access to clear simple instructions as to how to carry out certain tasks. For example, cleaning the theatre after use.
- Staff were trained to use the equipment and a competency framework was used to assess ability before being signed off as competent. We saw completed competency documents, which confirmed this. For example, we saw staff completed competencies in relation to using the different lasers. There was a different competency required for each different laser.
- The centre did not use capnography (measurement of carbon dioxide) when patients received intravenous sedation during their surgery. This was not in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI): Recommendations for standards of monitoring during anaesthesia and recovering 2016.

# Surgery

- We saw all areas were well maintained, free from clutter and provided a suitable environment for treating patients.
- Emergency and resuscitation equipment was accessible. Records indicated that equipment and consumables were checked daily which ensured they were available and fit for use. We checked 10 items and all were in date. The resuscitation equipment and emergency drugs were stored in a tamper evident trolley.

## Records

- CfSL used a mixture of an electronic patient record system (EPRS) and paper records. The EPRS was used to store all of the patients' records, any paper records were scanned into the electronic record. Diagnostic data was stored electronically. Patient pathway records were a paper record, this ensured all relevant information was in one place and followed a set pathway. There were different pathways for different surgical procedures for example, a laser and lens replacement.
- We reviewed two sets of paper patient records and found the records to be correctly filed and complete. We compared the paper records to the electronic files and saw that both sets of information were consistent.
- Patient records included information such as the patient's medical history, previous medicines, consultation notes, treatment plans and follow-up notes. There was a new appointment checklist, which was completed prior to the patient's first appointment. This included information about the patient; visual needs, eye history, lifestyle and payment details.
- Patient records were kept on site for two years securely when they were archived with a specialist record management company.
- Records included information specific to the treatment needed such as the recommended type and prescription of lens to be implanted during surgery based on various diagnostic tests. The serial number of the implanted lens was logged on the patient's records, as was any other equipment used during surgery. This meant if there were any issues with the implants discovered subsequently, the patient could be tracked.

- CfSL undertook quarterly records audits to ensure complete records were kept. Data provided to us showed in October 2017 the records audit showed 89% compliance.
- We saw that appropriate records were maintained each time a laser was operated and laser usage was recorded within the patient's record.
- If a patient contacted CfSO either during opening hours or the on-call member of staff out of hours, a patient query form was completed. This form included information relevant to their procedure, actions taken and confirmation of discussion and treatment plan with a doctor. This meant details of the query were documented in one place that all staff could access if required.

## Safeguarding

- There were no safeguarding concerns reported to CQC in the reporting period (April 2016 to March 2017).
- The Services Manager and the Operations Director were the location leads for both adult and children safeguarding. The Operations Director and Services Manager had completed level three adult and child safeguarding training in line with national guidance.
- All clinical staff completed level two adult and children safeguarding training. Administrative staff completed level 1 adult and children safeguarding training in line with national guidance.
- Safeguarding training was part of CfSL mandatory training programme. Data supplied to us by CfSL showed that 94% of staff had up to date safeguarding training, this was better than the 90% target.
- Staff had a good knowledge of safeguarding and were able to give us examples of concerns and what to do if they had concerns about a patient or their family.

## Mandatory training

- Mandatory training was undertaken via a SLA with an external company. Face to face, mandatory training days were undertaken two or three times a year with Subjects included but were not limited to; health and safety, fire safety, moving and handling, infection control, safeguarding adults and children and basic life support.

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- Ninety-four percent of staff were up to date with mandatory training this was better than the target of 90%. The Services Manager and the Operations Director oversaw training compliance. An electronic database was used to monitor compliance and we saw this during our inspection.
- The Services Manager and the Operations Director oversaw training compliance. An electronic database was used to monitor compliance and we saw this during our inspection.

## Assessing and responding to patient risk

- All patients completed a medical questionnaire and had a pre-assessment if required. Patients were categorised into three groups after completing the medical questionnaire: no pre-assessment required, telephone pre-assessment or face to face pre-assessment with a nurse. This was to ensure their needs could be met at CfSO. If their needs could not be met for example, they required a general anaesthetic for their procedure; they were referred to another provider.
- All necessary diagnostic tests were completed on the first appointment along with an assessment with the consultant. Patients were only offered surgery if deemed suitable.
- All patients undergoing intravenous sedation were cared for by an anaesthetist, they had their pulse, blood pressure and oxygen levels monitored. The anaesthetist continually monitored them and checked on the level of their sedation throughout the procedure. Oxygen was given to patients during their procedure if they required this.
- However, the centre did not use capnography (measurement of carbon dioxide in the breath) when patients received intravenous sedation during their surgery. This was not in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI): Recommendations for standards of monitoring during anaesthesia and recovering 2016. Capnography is used to monitor patients' breathing, and is the only way to make sure patients are breathing adequately while they are asleep or sedated.
- Staff demonstrated that it was possible to add an alert to a patient's electronic record, for example to highlight an allergy to staff.
- The centre used the 'World Health Organisation (WHO) "Five steps to safer surgery checklist." We observed the WHO checklist being completed in accordance with guidance. All staff knew what their role, responsibilities were in relation to the WHO checklist, and there was good staff engagement.
- The WHO checklist forms part of every patient treatment pathway and was audited monthly. The audit was observational and did not calculate a percentage instead, a description of compliance at each stage was documented.
- A staff briefing was held prior to each surgical session, this was attended by all staff involved in the surgery. The briefing reviewed a brief summary of each patient undergoing surgery and highlighted any specific issues or concerns, such as allergies, specific equipment requirements, anticipated difficulties and relevant past medical history. We observed a briefing, which contained all these aspects.
- Scenario training was undertaken in theatre of recognised complications. This included a checklist to follow and designated emergency equipment that was prepared in advance and ready to use in the event of a complication. This ensured staff remained confident and skilled should complications occur.
- The centre provided a 24-hour advice line, which patients could telephone following their surgery. All patients were telephoned on the same day of their surgery to check on their wellbeing.
- All lasers had safety checks and calibration undertaken before use, during a procedure when the laser settings were set a second person confirmed the settings and read them aloud to the surgeon. This ensured the power of the laser beam was checked and confirmed by the surgeon.
- The patients identity wristband was placed on the side that the surgery was being performed, this was a visual reminder to staff of the intended side for surgery. This was in addition to the surgeon placing a black pen mark above the eyebrow of the intended side for surgery. If the patient was having bilateral surgery, a wristband was placed on both wrists.

## Nursing and support staffing



# Surgery

- CfSL was a small organisation employing 32 staff, which included support staff therefore a specific staffing acuity tool, was not used. The staff rota was managed by the DoO in discussion with the Clinical Services Manager and Head of Optometry.
- Centre for Sight Limited employed 4.8 full time equivalent (FTE) staff which included ophthalmic technicians and optometrists, two FTE nurses and two FTE Operating Department Practitioners (ODPs) who worked across CfSO and Centre for Sight East Grinstead (CfSEG).
- Theatre staffing levels complied with Royal College of Ophthalmology guidance, this could be flexed according to the complexity and size of the operating list. We reviewed staff rotas, which confirmed that these staffing levels were adhered to. Staff told us there were enough staff on duty to maintain patient safety.
- CfSL had its own 'bank' of temporary staff that could be called upon when required. Only bank ODPs were used during the reporting period (April 2016 to March 2017). The use of bank ODPs and health care assistants in theatre departments was variable in the reporting period.

## Medical staffing

- CfSL employed three Associate Consultants who had an exclusive contract to work privately across all sites and six consultants with practising privileges. Practising privileges were reviewed on a bi-annual basis. The Medical Advisory Committee (MAC) reviewed and approved all practising applications and advised the Director of Operations on the granting, renewal, restriction and withdrawal of privileges. There had not been any restriction or withdrawal of practising privileges in the 12 months before inspection.

## Emergency awareness and training

- Fire exits were clearly marked and fire marshals were identified on posters on the walls. Fire evacuation scenarios were practised at least twice a year with the most recent one in September 2017. Staff had received fire safety training as part of the mandatory training package.
- Centre for Sight Limited had a business continuity plan which was used in 2016. In 2015, Centre for Sight East Grinstead suffered a large flood and was closed for six

months. The disruption was kept to a minimum and patients were transferred to Centre for Sight Oxshott. Because of this, the business continuity planning had been developed further for example, a checklist and contact list had been developed.

- We saw that the provider performed checks to ensure any new surgeon employed or granted practising privileges at the centre held the required level of training and experience to allow them to perform refractive eye procedures. All surgeons who performed refractive eye surgery at CfSL either held a certificate in laser and refractive surgery (CertLRS) or were on the GMC Specialist Register in Ophthalmology.
- We reviewed three consultant staff files and saw there was an effective process for the granting of practising privileges. All appropriate checks such as disclosure and barring service (DBS), General Medical Council (GMC) and specialist registration and health screening were carried out before practising privileges were granted.
- SfSL had a SLA in place with a local NHS trust, which ensured associate consultants had an annual appraisal, supervision and re-validation.

## Are surgery services effective?

Good 

We rated effective as **good**.

## Evidence-based care and treatment

- Care and treatment was delivered in line with current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Ophthalmologists (RCO) and the National Institute for Health and Care Excellence (NICE) guidelines.
- In theatres, we observed care and treatment was mostly in line with Royal College of Anaesthetists (RCoA) and RCoO local anaesthesia with ophthalmic surgery guidelines. For example patients undergoing intravenous sedation had their vital signs for example, blood pressure and pulse continuously monitored. However, the centre did not have capnography monitoring (measurement of carbon dioxide) to enable the monitoring of a patient's breathing.

# Surgery

- In theatres, NICE guideline NG77 Cataracts in adults: Management was adhered to. For example, there was at least one additional identical intraocular lens in stock at CfSO.
- We observed that NICE guideline NG77 was followed for the complete patient pathway, from providing the patient with enough information to make an informed decision through to post-operative assessment.
- Staff could access local policies and procedures electronically or paper versions and all staff we spoke with knew how to do this. Staff could access national guidance via the internet, and we saw computers available in staff areas to enable them to do this.
- We reviewed a variety of policies, which reflected care and treatment was current and evidence based. Policies we reviewed included but were not limited to infection control and prevention, medicine management and laser. All policies referenced national guidance.
- Centre for Sight Limited (CfSL) undertook 16 different audits, which were a mixture of local audits, and national audits, all were undertaken at different intervals throughout the year. Local audits included World Health Organisation 'Five Steps to Safer Surgery', laser room, medication, environmental and documentation.
- We saw meeting minutes, which confirmed monthly meetings within theatres and the centre, where NICE guidelines and compliance was discussed.
- CfSL's Medical Director was a committee member of the RCoO Refractive Surgical Standards Working Group (RSSWG) who developed and produced the new standards recently published and accepted by the General Medical Council (GMC).
- There was a holistic approach to assessing, planning and delivering care and treatment. Each patient's individual circumstances, occupation and hobbies were taken into account when deciding on care and treatment.
- High performance was recognised by credible external bodies. CfSL was asked by the Royal College of Ophthalmology to be part of a consumer programme as an example of good practice.

- Care and treatment arrangements fully reflected individual circumstances and preferences. Patients travelled from abroad to receive treatment on recommendations of the care and treatment provided. We were given an example of this during our inspection.
- In theatre, we saw an antiseptic solution was used to irrigate the eye immediately prior to the procedure starting. This was done to minimise the risk of infection and was in line with Royal College of Ophthalmology guidance.

## Pain relief

- We saw inpatient information booklets and leaflets contained information regarding pain relief methods that could be used during their procedure and postoperatively. Patients received verbal advice in relation to pain relief at pre-assessment, in patient information and prior to the procedure.
- Pain relief was provided preoperatively and additional pain relief medicines were prescribed for patients to take home to reduce pain at home and prevent dry eyes.
- During procedures, we observed theatre staff and the surgeon asking patients if they were experiencing pain. The two patients we spoke with during our inspection both said they received adequate pain relief.

## Nutrition and hydration

- The centre followed the Royal College of Anaesthetists guidance on fasting prior to surgery for patients undergoing intravenous sedation. The guidance suggested patients could eat food up to six hours and drink clear fluids up to two hours before surgery. Information regarding patient's fasting times was documented on the patient information at pre-assessment. In addition, patients were telephoned the day before their appointment and were verbally told when they could eat and drink up until. We saw that staff asked patients to confirm the time they last ate and drank before surgery. This ensured the service complied with the Royal College of Anaesthetists guidelines.
- There was a variety of hot and cold drinks available for patients and visitors and patients were offered a sandwich after their procedure.

## Patient outcomes

# Surgery

- The centre collected additional data sets to the minimum recommended by the Royal College of Ophthalmologists in order to monitor performance, outcomes and risks.
- CfSL had an audit programme which monitored patient outcomes and the effectiveness of procedures and policies in place. CfSL benchmarked against established or published data and patient outcomes consistently exceeded benchmarked data. Audit outcomes were discussed with the whole team as part of the meeting and communications structure and we saw evidence of this in meeting minutes. All staff were actively engaged in activities to monitor and improve quality and outcomes.
- CfSL used a proprietary outcomes analysis software program. All refractive surgery (laser and lens) data was entered pre and postoperatively for the entire time patients were treated at CfSL. Laser, refractive surgery patients who were stable were discharged at six months. Refractive lens exchange patients were usually discharged from care between six and 12 weeks. Those who were not stable or who required further care were followed for longer until stabilised. CfSL endeavoured to collect all data from every visit. Periodically datasets
- There is currently no widely validated patient-reported outcome measures (PROM) for cataract surgery. However, the Catquest-9SF questionnaire used by some organisations was used by CfSL. Catquest-9SF is a PROM tool that measures patients' ability to function before and after surgery. For example, patients were asked before surgery if they had difficulty reading a newspaper, recognising people's faces or had difficulty reading price labels when shopping and asked the questions again after surgery. CfSL had added questions to take into consideration the type of refractive cataract and lens surgery performed with trifocal lenses. Initial analysis on 300 consecutive patients revealed considerable improvement in function. For example, before surgery 40 patients answered they had difficulty reading a newspaper. After cataract and lens replacement surgery 25 (63%) patients said, their ability to read a newspaper had improved. Twenty patients said they had difficulty recognising people's faces before surgery. After cataract and lens replacement surgery 17 (85%) patients said, their ability to recognise people's faces had improved.
- CfSL performed well in the cataract surgery audit (The Royal College of Ophthalmologists Cataract Guidelines 2010) with 96% of patients achieving a best corrected visual activity of 6/12 after cataract surgery including refractive lens exchange. This was better when benchmarked against UK National cataract survey results of 85% (Desai 1999).
- Patient outcomes exceeded patient expectations and national survey results.
- Quality accounts were required for all health care organisations and the Royal College of Ophthalmologists had recommended a minimum data set. CfSL added more quality parameters to the data set, which related to the more commonly performed procedures for example, enhancement rates after refractive lens exchange and complication rates. This was for the provider's own purposes in order to monitor performance identify and address adverse clusters early. For example, posterior capsule rupture (PCR) in cataract surgery is a recognised complication of cataract surgery, therefore, this was monitored. CfSL had not had any PCR in the previous 12 months prior to our inspection.
- Visual enhancement following laser eye surgery and refractive lens exchange were other additional quality parameters monitored. Both of these were less than 1% in the previous 12 months prior to our inspection. Visual enhancement is undertaken when the vision is not acceptable to the patient after surgery. Low enhancement rates indicated consistently good and predictable outcomes.
- The centre engaged with the Private Healthcare Information Network (PHIN) so that data could be submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA). All providers of private healthcare in the UK, including most NHS hospitals, are required by law to submit data to PHIN.
- There were no cases of unplanned readmission within 28 days of discharge in the 12 months preceding our inspection.
- There were eight unplanned returns to theatres across Centre for Sight Oxshott (CfSO) and Centre for Sight East



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Grinstead (CfSEG) in the reporting period. These were for a variety of reasons and there were no themes, for example injection or removal of air or replacement or exchange of implant.

- CfSL presented outcome data for patients in a way they could understand. For example, improvements to vision to undertake everyday tasks or hobbies such as reading a newspaper or recognising people's faces. Presenting the data in this way meant patients had a clearer understanding of outcomes.
- Opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued. CfSL encouraged other experts within the field to come and observe and learn new and innovative procedures.

## Competent staff

- The centre followed "The Professional Standards for Refractive Surgery" (2017), aimed at surgeons and other medical professionals. These standards provide guidance on the level of experience and knowledge refractive surgeons should have, they also include the environment for performing surgery safely, good communication, teamwork and continuity of care. These standards were implemented in June 2017.
- All staff who worked for CfSL had received an appraisal at the time of our inspection. CfSL recently introduced a performance management system. All staff had a monthly one to one with their line manager, culminating in an annual appraisal in December. Historically, December was the least busy month of the year and this enabled focus on the strategic plan and objectives for the rest of the year. All team members had a one to one each month to discuss objectives and two way feedback, all objectives were set in line with the company's strategic plan.
- We observed there was a passion for education and CfSL provided six monthly education days for optometrists nationwide. Staff said that there was a focus on learning and development of the individual and the organisation. The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were

proactively supported to acquire new skills and share best practice. The centre offered a range of internal and external training opportunities to help staff continually learn.

- CfSL had a clinical competency framework, which staff completed, broken down into competencies for each area, for example working in theatre or working in outpatients. Line managers reviewed competencies and a competency forum was held periodically to assess competency across the organisation and feed into the organisational learning and development plan. We reviewed three staff files all of which contained completed competency documents.
- Staff induction had recently been revised based on feedback from the team and workshops held with staff as a result of working towards "Investors in People" status. Induction commenced with a half day workshop with the Director of Operations who explained the organisational structure along with the strategic plan and a checklist of mandatory information. New employees also watched videos of patients who had had an exceptional experience at CfSL so they could understand from the outset the level of service aspired to.
- The Head of Optometry played a large role in up skilling new employees on the types of treatments undertaken. This formed part of the CfSL learning academy, which was newly launched this year.
- We saw completed induction programmes during our inspection, which confirmed it was undertaken. We saw the induction programme was thorough and contained relevant information for example, the fire evacuation procedure.
- Staff were encouraged and supported to attend national conferences to ensure care and treatment reflected up to date guidance. Staff we spoke with confirmed senior staff encouraged learning.

## Multidisciplinary working

- In theatres, we observed that the whole team worked well together and all members of the team had a voice. Staff we spoke with reported positive multidisciplinary working relationships with colleagues. We observed 'team briefings' in theatres that were held prior to the

# Surgery

start of operating lists. Surgeons, anaesthetists, and theatre staff attended the 'briefings' which allowed the team to review the operating list together and highlight any particular issues.

- The centre had effective relationships with community eye practitioners such as optometrists, opticians and community nurses. Staff gave us examples of arranging community nurses to administer eye drops when the patient had been discharged home.

## Seven-day services

- The centre was open from Monday to Friday between 9am and 5pm and was closed at weekends.
- A 24-hour helpline for advice to patients outside of normal working hours was available. Consultants were available during normal working hours to review patients if staff felt medical input was required.

## Access to information

- Patient records were both electronic and paper based. All staff had access to full details of a patient's past medical history, medicines, allergies, referral letters, consent information, clinic notes, pre-assessment notes, and consultants' operation notes. Electronic records could be accessed at any of the three Centre for Sight Limited centres.
- We reviewed two sets of notes for surgical patients. Both contained sufficient information to enable staff to provide appropriate patient care. This included diagnostic test results and care plans.
- The centre provided discharge letters for patients and their GPs, unless patients requested otherwise. We saw that discharge letters included all relevant information to allow continuity of care in the patient's community. This included operation details, prescribed medications and eye care. Discharge letters contained details of the treating consultant so that the patient's GP could contact them if needed.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- CfSL had a consent policy, which was in date and was compliant with Mental Capacity Act and Deprivation of Liberty Safeguards legislation. The policy set out staff

responsibilities for seeking and obtaining informed consent, including the type of consent (verbal or written) needed for procedures undertaken at the centre.

- The service carried out an audit of consent which took into consideration the views of patients and the audit findings were positive.
- We saw the consent process started when a patient first contacted the centre, via telephone or via CfSL website. Specific procedure consent forms were sent by post to the patient, this gave patients time to thoroughly read and understand the benefits and risks of the procedure. Each consent form contained comprehensive information specific to the procedure.
- We observed that CfSL followed the 'New standards and patient information guidelines' published by the Royal College of Ophthalmologists. For example, there was standardised patient information, which explained the procedure, suitability, benefits, risks and alternatives.
- Patients were required to sign each page of the consent form to confirm they had read and understood the information it contained. Patients also had to sign to confirm they had been provided with all the relevant information. For example, they had been shown a video specific to their procedure. The responsibility for consent to procedures was undertaken by consultants, this took place at consultation.
- All surgical procedures were video recorded for teaching and legal reasons. There was a section on the consent form, which patients signed to give their permission for this. We reviewed two consent forms all of which had been fully completed.
- The centre had never had cause to seek a deprivation of liberty authorisation.
- Staff explained to us that the capacity of a person to consent to treatment was reviewed by consultants and staff during consultation and the pre-operative assessment stage. For those patients who lacked capacity a decision was made by the consultant if their needs could be met at the centre. If the consultant decided a general anaesthetic was required which could not be accommodated the patient would be referred to the NHS.

# Surgery

- Staff were aware of the minimum cooling off period for specific procedures and we saw that the minimum cooling off period of one week was observed.

## Are surgery services caring?

Good 

We rated caring as **good**.

### Compassionate care

- Staff introduced themselves to patients. During our inspection, we saw staff interacting with patients in a polite and courteous manner. The privacy and dignity of patients was maintained at all times.
- Patient dignity was maintained during surgical procedures. Patients remained fully clothed during operations.
- Patients we spoke with were positive about the care they had received. One patient told us “it had been much better than expected.”
- Patients completed patient questionnaires, which enabled patients to provide feedback on the care they received at Centre for Sight Limited (CfSL). CfSL used the five Friends and Family questions within the patient survey.
- CfSL did not provide information split into the individual centres. The latest survey results (September 2017) showed that 87% of patients would recommend CfSL to friends and family. This was below the CfSL target of 95%.
- Feedback from these questionnaires showed that patients felt that they received warm and friendly care. Patient comments included “I felt I was in good hands right from the first consultation.”

### Understanding and involvement of patients and those close to them

- Patients, friends and relatives were greeted on arrival at the centre and met by the team prior to proceeding with surgery. Whilst patients proceeded through the surgical care pathway, staff kept the family informed, in particular when surgery was over and the patient was recovering.

- Postoperative instructions were in a printed booklet and reviewed with the patient and a member of their family prior to discharge. We observed that staff checked with friends and relatives that they also understood the aftercare instructions.
- The centre provided information to patients, prior to surgery informing the patient that they would need to be accompanied after surgery and would be unable to drive.

### Emotional support

- All patients we spoke with felt staff had given them sufficient information about their procedure, and were able to discuss it with staff. We saw staff give the patient comprehensive written and verbal information about their on-going care. This included eye care, follow-up appointments, hobbies and counselling on medicines. This helped patients understand how to care for themselves and recognise any post-operative complications.
- Patients had the opportunity to talk to other patients who had undergone surgery if they wanted, this was facilitated by CfSL staff.
- On the CfSL website, there were testimonials of patients who had previously undergone procedures. This provided support for patients as they heard it from a patient’s perspective.
- Patients were positive about the support and reassurance they received. One patient comment included, “The efficiency and kindness of staff and their patience in answering questions meant that I began to learn to trust your professionalism on that first day.”
- We saw staff went to any lengths to try and relax patients, for example, they were left to wait in the waiting area right up until just before their procedure. This meant they were in a relaxed surrounding with their relatives or friends.
- The centre welcomed relatives to stay with patients prior to and after surgery.
- There was a coordinator who worked in clinic alongside the clinical team to provide support to the receptionists and technicians in ensuring patients were kept up to date on the time of their procedure.

# Surgery

## Are surgery services responsive?

Good 

We rated responsive as **good**.

### Service planning and delivery to meet the needs of local people

- Follow up appointments were offered to all patients, on the day after surgery. These appointments involved aftercare advice, assessment for risk of infection or side effects.
- Surgery was undertaken once a month at Centre for Sight Oxshott (CfSO) for patients who preferred not to travel to Sussex to another centre. Appointments, including follow up, could be undertaken at any of the three Centre for Sight locations depending on patient preference.
- CfSL provided private healthcare treatment. Patients could either self-pay or use private health insurance. Patients could self-refer or be referred by another healthcare agency for example an optician.
- We saw that the facilities were modern and fit for purpose. Staff and patients were positive about the environment.
- There was telephone based pre-assessment available for patients having procedures. This meant patients who were considered low risk for an operation could have their pre-assessment done over the phone, which avoided a visit to the centre.
- All admissions for surgery were elective and planned in advance therefore service planning was straightforward as the workload was mostly predictable.
- As specialists in ophthalmology practice in the local area, some patients sought a second opinion and repair of previous complications from surgery. This meant patients could access specialist care.
- CfSL had a charity scheme where patients who no longer needed their glasses after their procedure donated them to charity. CfSL collected all the

unwanted glasses and sent them to a charity factory. The glasses parts were used to make glasses for developing nations around the world where glasses provision was not as accessible.

### Access and flow

- Consultants did not have waiting lists. Patients could typically be booked in for procedures at the patient's convenience subject to the ordering of any bespoke lenses. Emergency slots were available in outpatient clinics in case of the need for a patient to see a consultant urgently. There was always scope for a patient to be treated urgently by one of the three directly employed consultants.
- CfSL appointment system and surgical lists were all managed centrally. This enabled the movement of staff where they were needed to meet the needs of the clinics and theatre sessions.
- All calls were triaged by an experienced medical administration team and information was passed on to technicians. Technicians were rostered to cover any enquiries on a daily basis and to deal with any clinical queries. An ophthalmic consultant was always available to advise and sign off on queries and see patients when necessary.
- When there was a rise in requests for theatre availability, additional theatre slots were provided to meet demand.
- The service had not cancelled any procedures due to a non-clinical reason from April 2016 to March 2017.
- During our inspection, the theatre list ran on time. The inspection did not highlight any concerns relating to the admission, or discharge of patients from the ward or theatres.
- Patients arrived at the centre either in the morning or at lunchtime depending on where they were on the operating list. Staggered arrival times meant waiting for patients undergoing sedation nil by mouth time was kept to a minimum.
- Pre- procedure checks and assessments were undertaken, when completed the patient waited in the waiting area until the time for their procedure.

### Meeting people's individual needs

# Surgery

- The centre had access to face-to-face and telephone interpreters for a range of different languages. Staff we spoke with knew how to book interpreters and gave us examples of times patients had used translation services.
- Patient information was available in large font if required for patients who were visually impaired.
- The centre provided an induction hearing loop in the reception area. A hearing loop is a sound system for use by people with hearing aids.
- The centre had wheelchair accessible toilets and a wheelchair available for patients to use if required. There was a disabled lift for wheelchair users to use.
- When a patient made initial contact with CfSL, they were allocated a patient liaison coordinator. The coordinator was responsible for organising the logistics of the patients journey, for example making appointments and sending reminders of appointments. This ensured continuity of care for patients and they knew whom to contact if they experienced any problems.
- If a patient was assessed and their needs could not be met at the centre they were referred to another facility, for example a NHS trust.
- Depending on the type of complaint, advice was sought from the Medical Director and company insurance lawyers. Any information pertaining to the investigation was kept together in a complaints folder. We saw the complaints folder during our inspection.
- Complaints were acknowledged within 48 hours. Complaints were investigated and typically, a response was carried out within 10 working days. We saw evidence of compliance with these timescales in the complaints folder. If this timescale could not be met, the patient making the complaint would be informed but given a timescale with reasons for any delays in response.
- Complaints were a standard agenda item of centre meetings and we saw confirmation of this in meeting minutes. Learning was disseminated in this way. Processes were also changed as a result, for example new terms and conditions were introduced to ensure better clarity for patients on billing processes.
- We saw posters in the centre, which contained information on how to make a complaint.
- If the complaint could not be resolved locally, the patient was given the contact details for the Independent Healthcare Sector Complaints Adjudication Service.

## Learning from complaints and concerns

- CfSL had a system for handling complaints and concerns and followed the organisation's complaints policy. This provided a structured process for staff to follow when dealing with complaints. We reviewed the policy, found it was in date, and reflected recognised guidance and contractual obligations for independent hospitals in England.
- The Director of Operations (DoO) determined who would lead the investigation based on how and where the complaint originated. For example if the complaint was regarding waiting times in clinic, the Head of Optometry would be asked to investigate. The outcome of the investigation was then fed back to the DoO and a formal written response compiled. The DoO often investigated complaints, as they were responsible for the final written response.
- All staff received annual training in handling complaints with the focus on trying to resolve complaints informally at the time of the complaint.
- CfSL received 16 complaints in the reporting period (April 2016 to March 2017) across all three centres. CfSL did not supply us with complaints data broken down by site. However, we reviewed the complaints log during our inspection and saw the specific centre the complaint related to was recorded. There were no themes identified within the complaints log. This meant managers knew where complaints happened and could identify any themes if there were any. No complaints were referred to the Independent Healthcare Sector Complaints Adjudication Service in the same reporting period.

## Are surgery services well-led?



# Surgery

Outstanding



We rated well-led as **outstanding**.

## Leadership / culture of service related to this core service

- Centre for Sight Limited (CfSL) was led by the management team, which was made up of the Chairman, Consultants and the Director of Operations (DoO). A team of managers reported directly to the DoO who had set objectives in line with the company's strategic plan.
- There were four staff groups, which formed the CfSL organisation, each group had a manager or managers and were supported by a team. For example, the clinical team had a Theatre Manager, Head of Optometry and a Clinical Services Manager who managed a group of eight staff.
- We saw strong leadership, commitment and support from the management team. They were responsive, accessible and available to support staff during challenging situations. Staff said that their work life balance was good and their managers were very flexible and accommodating.
- All staff told us clearly about their lines of reporting to the management team and told us they felt valued, supported and respected in their roles. Staff told us they thought managers were very supportive and that there was clear leadership from them.
- Staff told us one of the best things about working at the centre was the team. Staff descriptions of the culture included "we are like a family."
- There were high levels of staff satisfaction across all staff groups. Staff spoke highly of the culture. There are consistently high levels of constructive engagement with staff. Staff at all levels were actively encouraged to raise concerns.
- There was strong collaboration and support across all aspects of CfSL and there was a common focus on improving quality of care and people's experiences. For example, the leadership team undertook prompt action to address patient feedback.
- We observed positive working relationships between staff. Due to the small size of CfSL, everyone knew each other and we observed friendly interactions between staff at the centre.
- Managers we spoke with appeared knowledgeable about their patient's needs, as well as their staff needs. They were dedicated, experienced leaders and committed to their roles and responsibilities. Leaders had an inspiring shared purpose, strive to deliver and motivate staff to succeed.
- Staff knew their role within the team and how this contributed to the cohesive organisation of CfSL. Staff also had awareness of colleagues' roles within the team and how they contributed to the team.
- Staff we met were all welcoming, friendly, and helpful, morale was good, and staff told us they felt 'proud' to work at CfSL.
- There was a strong culture of openness and transparency, CfSL actively encouraged staff to raise concerns. For example, during the World Health Organisation 'Five steps to safer surgery' checklist briefing staff were asked if they had any concerns regarding the operating list.
- Staff were committed to making improvements for patients and felt they had been given the right resources to achieve this. Staff said they focussed on providing good care "the sort of care you would want to experience yourself."
- The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care.

## Vision and strategy for this core service

- CfSL had a strategic learning and development plan, this ensured knowledge within the organisation benefitted patients.
- The five key lines of enquiry (safe, effective, caring, responsive and well-led) were incorporated into CfSL strategic plan. The components of the strategic plan were discussed with the team on a regular basis as part of the communications structure. We saw confirmation of this within the centre's meeting minutes.
- CfSL overall vision was focused on exceeding expectations both in terms of outcomes and experience,

# Surgery

striving to provide phenomenal outcomes by customising patient care provision. This was achieved by continued education team development and investment in technology. There was vigorous audit of patient outcomes and experience and action taken on results of these. We saw staff had an ongoing education programme, which ensured their skills, and knowledge were kept up to date. CfSL maintained an asset register of all equipment, which contained life expectancy of equipment, which ensured equipment, was replaced appropriately.

- CfSL team determined their values together as an organisation during a team building day. Staff decided on a set of words, which defined their values “We are Safe”; “Ethical”; “Patient Centric”; “We Care”; “We are Honest and Transparent.”
- The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable.
- At the end of 2016, CfSL embarked on Investors in People accreditation process and spent time as a team considering their values and how they worked together as a team. CfSL held team building events to understand how they worked together.
- Staff were able to describe to us the vision and values of CfSL. We were told this also formed part of the interview process and saw it was part of the appraisal process.

## **Governance, risk management and quality measurement (and service overall if this is the main service provided)**

- The service had an effective governance framework. The Medical Director had overarching governance responsibility who fed into three other committees, Consultants, Operations Director and Finance Manager. These fed into four other staff groups which included medical administration, marketing and enquires, finance and clinical staff. This structure ensured the two-way sharing of information and dissemination.
- CfSL had a clinical governance policy, which was in date. This policy set out the key systems and processes that underpinned the organisation’s approach to clinical governance. The overarching clinical governance was

implemented by strategies which included; education and training, risk management, audit, communication, complaints, evidence based practice research and development.

- Medical Advisory Committee (MAC) meetings were undertaken quarterly. At this meeting, the company risk register and practising privileges were reviewed. We saw from meeting minutes that the meetings followed a set agenda with input from the multidisciplinary team. New national guidance was discussed and changes implemented. Introduction of new technology was discussed in terms of benefit, commissioning and training. For example, we saw the implementation of the electronic patient record was discussed and how the implementation was managed.
- CfSL undertook monthly clinical meetings and quarterly centre and consultants meetings. We saw from meeting minutes that the meetings followed a set agenda, which included but was not limited to; incidents, review of policies, training, laser audit, care pathways, complaints and quality standards.
- Staff confirmed they received information during the meetings and gave examples of learning from incident investigations.
- We saw CfSL was working towards ISO 27001 certification. ISO 27001 is a specification for an information security management system (ISMS). An ISMS is a framework of policies and procedures that includes all legal, physical and technical controls involved in an organisation's information risk management processes.
- The centre had many service level agreements (SLA) which provided services. For example, pharmacy services, laundry, cleaning, facilities and estates management. We reviewed two SLAs which were in date and defined the type of service provided, required performance level, monitoring process, steps on how to report matters affecting performance and a review date of the SLA.
- CfSL had a risk management policy, which was in date. The policy clearly defined staff roles and expectations with regard to reporting and responding to risk.
- SfCL had a risk register, which included 13 risks, the register included risks for each centre location and

# Surgery

companywide risks. We reviewed SfCL risk register and noted that all 13 highlighted risks had been reviewed within the last 12 months. We saw that all risks had controls in place to mitigate the risks. For example, the risk of a major incident such as a flood was mitigated by a business continuity plan. Staff at the Oxshott centre told us that although the flood at the East Grinstead centre was extremely disruptive and unfortunate, they were now better prepared to deal with such incidents.

- CfSL's strategic plan included a scorecard with a traffic light system for identifying work still to be done, areas of improvement and areas of success.
- CfSL had a performance dashboard, which monitored monthly performance in a range of key areas. These included monthly WHO five steps to safer surgery audits, laser audits, consent, hand hygiene and medical records. We saw in meeting minutes results from these were discussed at clinical meetings.
- CfSL produced quarterly quality standards, which included but were not limited to complaints, adverse incidents and patient satisfaction. We saw from meeting minutes these were discussed at MAC meetings and consultant meetings.

## Public and staff engagement (local and service level if this is the main core service)

- CfSL also collected patient feedback via testimonials, patient complaints, patient thank you cards, and from staff talking with patients. Feedback was discussed at team meetings and processes changed based on feedback, we saw confirmation of this in staff meeting minutes.
- For example, patient's feedback included that they experienced long waiting times in outpatient clinics. Because of this feedback, CfSL adjusted the appointment templates in June 2017. At the time of the inspection, we saw an audit was planned to gain feedback from patients in order to monitor improvement.
- We saw cards and leaflets on the wards with information for patients on how to leave feedback. In addition, the centre's website had the facility for patients to leave feedback.
- CfSL had a website where full information could be obtained about the treatments available for patients. It

was very comprehensive and included information about costs and finance. The website also included advice and tips for patients for example on the safe use of contact lenses.

- Patient seminars were held quarterly at both East Grinstead and Oxshott locations. Patients had the opportunity to visit the premises and meet the team. They listened to a seminar provided by one of the consultants and were able to ask questions and speak with past patients.
- CfSL website also included 10 tips if patients were considering eye surgery, to find out if Laser eye surgery was right for them. It also gave information on what to consider if they were thinking of having laser eye surgery.
- CfSL interacted on social media via Facebook, Twitter and LinkedIn. social media.
- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaires and website.
- We saw from the various CfSL meeting minutes that they were well attended by staff and the managers. These meetings gave staff the opportunity to raise any concerns or discuss new ideas on ways of working.
- Staff received a performance based salary bonus annually based on annual achievements and individual objectives being met.
- The management team organised activities and away days for staff as team building events. Staff informed us that management were proactive and that they felt confident to approach their immediate manager with any concerns. Staff told us they were regularly praised and given positive feedback from managers.

## Innovation, improvement and sustainability (local and service level if this is the main core service)

- CfSL had a Centre for Sight Trust, which supported eye-care in developing countries. Using derived donations and charitable contributions the objectives of the trust were to develop eye care in developing countries and promote innovative eye research in the








# Surgery

UK. The Medical Director undertook annual visits Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) in April 2015 to assess patients and perform surgical procedures.

- CfSL were focussed on innovation and the development of new techniques. CfSL consultants had designed instruments in collaboration with manufactures of ophthalmic instruments.
- A new technique for dislocating the lens in laser cataract surgery was devised by the medical director and this culminated in a new instrument and a publication in a professional journal.
- The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated.
- CfSL was ISO 14001 certified and went through an annual process of renewal. ISO 1400 is a set of CfSL was committed to environmental management and we saw posters and receptacles encouraging staff, patients and visitors to recycle whilst at the centre.
- Education was a huge part of the culture at CfSL and an important contributor to the eye care network. We saw this evidenced in international and national journal papers written by one of the consultants and the same consultant speaking at national and international conferences. Each year CfSL held two education days for optometrists, the last one was 17 October 2017. The day consisted of lectures as well as live 3D surgery broadcast to the waiting room, which was converted to an auditorium.
- High performance was recognised by credible external bodies. The Royal College of Ophthalmologists (RCOphth) was approached by a television channel to help with the production of an episode of a consumer programme regarding laser eye surgery. In September 2017, CfSL was part of this programme, which highlighted the need for patients to research the procedure and find out what was involved as well as making a good and informed choice of procedure, surgeon and centre.

# Outpatients and diagnostic imaging

Safe	Good 
Effective	Not sufficient evidence to rate 
Caring	Good 
Responsive	Good 
Well-led	Outstanding 

## Are outpatients and diagnostic imaging services safe?

Good 

### We rated safe as good

#### Incidents

- Patients were protected from the risk of inappropriate or unsafe care because there were systems to ensure that incidents were identified, reported, investigated, and learned from to prevent recurrence. Centre for Sight staff had a good understanding of the processes to report incidents. The Director of Operations reviewed incidents and investigations and outcomes were shared with staff through staff meetings.
- Staff were able to describe what the Duty of Candour was. This relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- For our detailed findings on incidents, please see the safe section of the surgery report.

#### Cleanliness, infection control and hygiene

- All areas we visited within the centre were visibly clean and tidy, and we saw there were good infection control practices.
- We saw the outpatients department had carpeting in the reception area, corridors, and the diagnostic treatment room. The consulting room we visited on the

ground floor had easy to clean vinyl flooring. Carpets in the diagnostic treatment room prevented effective cleaning. However, we saw carpets in the reception area; corridors and diagnostic treatment room were visibly clean and free from stains. We also reviewed records which confirmed deep cleans of carpets had taken place monthly.

- Throughout the outpatients department seats were available. These were made of easy to clean materials. However, in the reception areas some of the chairs were upholstered. The operations manager told us they were made of medical grade upholstery but we were unable to confirm this during the inspection.
- There were sufficient hand washbasins (HWB) available. Soap cartridges and disposable hand towels were available next to the sinks. We also saw alcohol based hand gel was available throughout the centre. In the diagnostic treatment room, we observed two members of staff using hand gel prior to delivering patient care and on entering and leaving the room.
- Information about the World Health Organisation (WHO) 'five moments for hand hygiene' and the correct procedure for cleaning hands was displayed near the HWBs. This helped remind staff of the importance of when and how to clean their hands, before and after key activities such as before and after patient contact.
- We saw all staff in the outpatient area were 'bare below the elbow'. This was in line with national guidance 'National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England' (epic3), which says healthcare workers should ensure they clean their hands effectively by removing all wrist and hand jewellery.

# Outpatients and diagnostic imaging

- We saw sharps bins were available in clinical areas and consulting rooms where sharps may be used. This demonstrated compliance with health and safety sharps regulations 2013, 5(1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw the 'sharps' bins were correctly assembled, labelled and dated. None of these bins were more than half-full, which reduced the risk of needle-stick injury. Labels on sharps bins had been fully completed which ensured traceability of each container.
- We found equipment was visibly clean at the centre, and staff had a good understanding of responsibilities in relation to cleaning of equipment. Disinfectant and detergent wipes were available in the clinical and consulting rooms to clean equipment between patient contacts. Good levels supplies were seen throughout the centre. However, we saw not all equipment had a label informing staff equipment had been cleaned following use on a patient. This meant staff would not know if equipment was clean and was safe to use. Staff told us they would always clean equipment before they used it. We observed staff cleaning equipment prior to use.
- Cleaning equipment was stored in a designated room, which was locked. We found the room to be clean and tidy. The cleaners used a colour coding system that was based on the national guidance for colour coding to prevent the spread of infection. The cleaner attended the centre each evening for two hours (Monday to Friday).
- Infection prevention training was completed by all staff as part of their mandatory training. All outpatients department staff had completed this training.

## Environment and equipment

- The outpatients department was situated on two levels. The environment of the outpatients department was well maintained and free from clutter. The outpatients department consisted of two consulting rooms and two imaging / testing rooms.
- There was a resuscitation trolley in the theatre area, which was next to the outpatients department. The resuscitation trolley was secure and we saw that records of equipment and consumables checks were up to date.

Staff ensured all trolleys were fully stocked with equipment needed in a resuscitation emergency. All consumables were in date. Staff checked the trolleys daily.

- In the ground floor diagnostic treatment room, we observed four pieces of medical equipment, which had undergone electrical safety testing. We observed from the stickers that the equipment was in date and was due to be tested again in January 2018.
- In the ground floor diagnostic treatment room, we observed an equipment checklist was in place for the diagnostic equipment. The checklist was completed for each day the clinic was open over the last six months. The checklist was a record of the calibration (the process of evaluating and adjusting the precision and accuracy of measurement equipment readings of the equipment). This ensured that the equipment was working within the correct parameters.

## Medicines

- In the outpatients department we observed an unlocked general purpose cupboard. Within the cupboard, we found approximately 100 boxes of prescription eye drops. During the unannounced inspection, we saw the eye drops had been removed from the cupboard and a cupboard in theatre had been found for their storage. The temperature of the theatre was monitored daily and the theatre was locked when not in use.
- We observed there was a designated bin was available for the disposal of medicines. The box was correctly labelled as per national standards.
- In the first floor consulting room the fridge for the storage of medicines were seen to be clean. Fridge temperatures were within the recommended range of 2-8 degrees Celsius. There was an automated temperature gauge, which would alert staff if the temperature was to fall or increase out of the recommended range for medicines storage. The temperature of the fridge was checked daily and recorded. We saw completed records, which confirmed this.
- Medicines were provided by a nearby NHS hospital trust and private provider, who gave pharmacy advice if required.

# Outpatients and diagnostic imaging

- A consultant prescribed all the patients' medicines. We saw evidence in the patient electronic records of medicines being prescribed by a consultant.
- During the unannounced inspection, we observed the prescription pad was stored in a locked drawer in one of the consulting rooms. This was a change to the previous inspection when we found pharmacy prescription pad stored in an unlocked drawer. This meant the provider had listened to our concern and taken action to address it. All the prescription sheets were numbered. A logbook was available to record the prescription sheet number, date, name of patient and medicine prescribed. The prescription would be scanned into the electronic system by the receptionist before leaving the centre to ensure there was an entry in the in the patient's records.
- For our detailed findings on medicines, please see the safe section of the surgery report.

## Records

- The centre used both a paper and electronic based record system to record all aspects of patients' care. All patient records were available when a patient attended for a consultation in outpatients due to the records being held electronically.
- Paper patient records were held on site and were retrieved from storage prior to the consultation. We found the majority of paper records were kept in a security locked cupboard. However approximately 100 sets of paper records were kept in a second general purpose cupboard without a security code in an unlocked filing cabinet. The second cupboard was not secure but it was in an area only staff accessed. At the reception desk, a locked filing cabinet held the paper records for the day's clinics.
- We reviewed five sets of paper patient records and found the records to be correctly filed and in good condition. We compared the paper records to the electronic files and saw that both sets of information were consistent. Ninety-per cent of records were electronic with limited paper records.
- Paper patient records were transferred between the East Grinstead and Oxshott sites in a secure hard box with a

security code for opening. The box provided a secure way to transfer the patient records. After two years, paper records were transferred to East Grinstead for storage.

- Following a referral to the centre, the booking staff would contact the patient and undertake a telephone checklist. An email would then be sent to the patient asking them to complete information including 'your information', terms and conditions and an email consent form. In the five records we reviewed, we saw all the appropriate documentation was in place.
- In the paper records, we saw patient query forms were completed when a patient telephoned with a query. The form documents the query and the actions taken, these were all signed and dated. In the records we reviewed, we saw queries had been passed on to the clinician on duty and the appropriate actions were taken. The consultants were informed of the query and signed off the actions.
- The Director of Operations told us that a package rate fee would be charged for the first appointment that covered the consultant's time and diagnostic tests. Following this appointment, a personalised quote would be written and given to the patient along with the payment methods. We reviewed three letters sent to patients and saw the information was clearly set out.
- To confirm patient's identification a photograph was taken when they first attended the clinic. Verbal consent was gained before taking the photograph. This photograph was placed in the electronic records and was used to confirm patient identification before each consultation.
- For our detailed findings on records, please see the safe section of the surgery report.

## Safeguarding

- Staff had access to the safeguarding policy for vulnerable adults and children and were given a copy of this to read when they commenced employment and received annual training on safeguarding.
- The centre treated a small number of children aged between 13 and 16 years old in outpatients. A member of staff with level three child safeguarding was always directly involved when a child was receiving treatment.

# Outpatients and diagnostic imaging

- For our detailed findings on safeguarding please, see the safe section of the surgery report.

## Mandatory training

- For our detailed findings on mandatory training, please see the safe section of the surgery report.

## Assessing and responding to patient risk (theatres, ward care and post-operative care)

- In the cleaning cupboard, we reviewed a folder containing safety data sheets and risk assessments for the cleaning fluids subject to 'Control of Substances Hazardous to Health' regulations. This gave staff information on first aid measures, firefighting measures, handling and storage, personal protection and disposal considerations. This meant staff had the necessary information available in an emergency.
- For our detailed findings on assessing and responding to patient risk, please see the safe section of the surgery report.

## Nursing staffing

- In the outpatient's department, 4.8 whole time equivalent (WTE) ophthalmic technicians and optometrist were employed and worked across both the Oxshott and East Grinstead sites. The Director of Operations told us staffing requirements were based on the surgeon in clinic and demands based on complexity and numbers of patients seen.
- The Oxshott clinic had a receptionist who worked Monday to Thursday 8.30 to 4.30pm and the occasional Saturday once a month.
- For our detailed findings on nursing staffing please, see the safe section of the surgery report.

## Medical staffing

- The doctors held clinics for the patients following surgery and there were clinics for other conditions as well as yearly reviews and new patient clinics.
- For our detailed findings on medical staffing please, see the safe section of the surgery report.

## Emergency awareness and training

- The centre had a Business Continuity policy (updated April 2017) which was placed on the wall in outpatients. The policy covered major incidents such as a terrorist attack, flood, fire and extreme weather and loss of utilities.
- We saw CCTV around the centre and there was a security entrance system, which was activated by the receptionist at the entrance to the centre.
- We saw a biohazard spill kit and first aid kit available in the outpatients department. Both kits were in date.
- We observed a fire assembly point was outside and throughout the centre, fire extinguishers were in place. All the fire extinguishers had been checked by the fire service and were due to be checked again in 2018.
- For our detailed findings on Emergency awareness and training, please see the safe section of the surgery report.

## Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate 

## Evidence-based care and treatment

- For our detailed findings on evidence-based care and treatment, please see the effective section of the surgery report.

## Patient outcomes

- For our detailed findings on patient outcomes, please see the effective section of the surgery report.

## Competent staff

- The two ophthalmic technicians told us they had received training on each diagnostic piece of equipment by a senior technician and were competency assessed prior to using the equipment independently. We reviewed the training records and saw that the staff had completed their competencies for each piece of diagnostic equipment.
- Competency assessments were undertaken by the ophthalmic technicians to administer eye drops. We reviewed the records and saw that training had been completed. An optometrist was responsible for

# Outpatients and diagnostic imaging

undertaking the assessment and signing off the competencies. All records were correctly completed. We saw competency packages were in place for medicine management and diagnostic equipment with formal reviews taking place every six months.

- We reviewed the ophthalmic technicians training programme and saw that training had been completed in glaucoma, visual fields, and refraction.
- Housekeeping staff had received appropriate training and we were able to review the cleaner's record of competency. We observed training had been completed yearly and included fire procedures, manual handling, workplace equipment and the health and safety policy.
- Staff informed us they had an annual appraisal and the appraisal date was twelve months following their start date. All staff at the centre had had an appraisal.
- Staff informed us that they were given opportunities to improve and develop.
- Monthly training was undertaken by one of the consultants. All staff were invited. We saw in August 2017, the anatomy of the eye was the training given to staff. In September 2017, we saw training was given on Intense Pulse Lighting.
- One staff member told us they had introductory training, which took six weeks to complete, and involved spending a week in different areas of the service. A buddy was appointed and one to ones were undertaken by the manager.

## Multidisciplinary working

- Staff in the outpatient department worked with the surgical department staff and with the consultants. Staff told us they all worked as part of one team.
- Staff told us good working relationships were in place with staff at the other centres as staff rotated between Oxshott and East Grinstead.
- For our detailed findings on Multidisciplinary working please, see the effective section of the surgery report.

## Access to information

- All policies, protocols, guidelines, and standard operating procedures were available electronically in the centre.

- We saw that there were computers for the use of staff in the centre. Staff across all three centres were able to access relevant information to undertake their role.
- For our detailed findings on access to information, please see the effective section of the surgery report.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a corporate consent policy, which was in date and was due to be reviewed in June 2018. Staff demonstrated a good understanding of the consent process for the outpatients department and informed us that patients were fully informed and included in the assessment and treatment plan.
- Staff in the outpatients department understood the importance of patients giving consent prior to any interventions or assessments. We reviewed five sets of patient records and consent forms were signed and dated.
- We observed a new patient consultation and saw the ophthalmic technician confirmed the identity of the patient prior to undertaking the diagnostic tests. Consent was obtained prior to carrying out each test. We saw that one test needed repeating due to the poor quality of the scan. A clear explanation was given to the patient as to why the scan needed repeating.
- All patients gave consent to consultants in a two stage process. After the first consultation, we were told there was a cooling off period of one week. We reviewed five sets of patient records and saw that the cooling off period was in place in all the records we reviewed.
- Where a patient was having treatment on both eyes there would be two consent forms, one for each eye as recommended within National Institute of Health and Care Excellence (NICE) guidance. This was seen in patient's records we reviewed.

## Are outpatients and diagnostic imaging services caring?

Good 

We rated caring as **good**.

## Compassionate care



# Outpatients and diagnostic imaging

- We saw that staff were caring and compassionate and they treated patients with dignity and maintained their privacy. We observed two ophthalmic technicians who greeted patients professionally in a calm manner and explained the treatment they were about to carry out.
- We observed during a consultation that the ophthalmic technician asked the patient if they were ok throughout the test and offered the patient a break if they needed it. Water was also offered. This showed the caring and compassionate side of the staff.
- Patients we spoke with felt that they were well informed about their care and staff were very helpful and caring. One patient told us that the ophthalmic technicians were excellent and the centre was chosen due to its good reputation.
- We observed staff escorting patients to other clinic rooms, and asking if they would prefer to take the lift or stairs. Staff at all times were professional with good lines of communication between themselves and the patients.
- When patients arrived, we observed the reception staff to be friendly and very professional placing the patients at ease. A verbal identification check was made and the patient records were then transferred to the clinical staff.
- At the reception area, patients were offered a private room to discuss any information in private.

## Understanding and involvement of patients and those close to them

- We observed a new patient consultation and saw the ophthalmic technicians clearly involved the patient and explained a series of diagnostic tests they would be undertaking. A very thorough explanation of what each test involved and why it was needed was given to the patient. The patients were reassured throughout the tests.
- We observed one ophthalmic technician confirming with a patient that they had not driven to the centre before dilating the pupils. This ensured the safety of the patient after the procedure and ensured the patient was fully involved in the process and understanding the risks.
- We spoke to two patients who were very positive about the service and we saw that patient's relatives were

supported when they attended the clinics. In the September 2017 patient satisfaction survey, 76% of patients felt they 'were involved in their care and treatment.'

## Emotional support

- We observed staff greeting patients arriving for the outpatient's clinic by name. The staff and the environment of the centre provided calming and supportive treatment for patients. Patients received one to one care.
- The Director of Operations told us that if patients required support they would be able to refer to services at the local NHS trust.

## Are outpatients and diagnostic imaging services responsive?

Good 

We rated responsive as **good**.

## Service planning and delivery to meet the needs of local people

- Patients had access to a public car park close to the centre. The main building was well signposted on the main road and close to main public transport routes.
- The main entrance was at the front of the building. Patients pressed a buzzer and reception staff let them in the main door and then guided patients to the area they needed to go to.
- Waiting areas had comfortable seating arrangements and free tea and coffee was available from a dispensing machine. We saw the temperature of each waiting room was comfortable and the areas were visibly clean and tidy.
- Patient toilets were available on all outpatient levels, these were clean and facilities available to wash hands.
- For our detailed findings on service planning and delivery to meet the needs of local people working please, see the responsive section of the surgery report.

## Access and flow

# Outpatients and diagnostic imaging

- There were 803 outpatient attendances in the reporting period, (April 2016 to March 2017) all of which were privately funded .Of the 803 attendances, 199 were first attendances and 604 were follow up appointments.
  - Outpatient clinics ran once a month on a Monday morning from 9am to 1pm.This clinic reviewed new patients, annual reviews and follow up appointments. A second clinic took place on Thursday afternoon, which was a one day follow up clinic. There were no out of hours clinics or clinics at weekends. Appointments were flexible and days and times of appointments were changed to meet the patient's individual needs. Patients were able to attend any of the centres for sight clinics depending on their needs. Children (aged six -17 years) would be seen at the beginning and end of the Monday morning clinic.
  - Pre-operative appointments were offered within one to two weeks following referral. Patients would be telephoned following the referral to establish where they wished to be treated. This would be followed up in writing confirming the date, time and address of the centre. Staff would accommodate a patient's request if they needed to amend the appointment.
  - Staff informed us that if an appointment was available at short notice they would contact patients and offer these over the telephone. All bookings were made by the booking team at East Grinstead who sent out all the necessary documentation.
  - Telephone consultations by a clinician took place following surgery to ensure the patients were recovering and there were no issues developing before attending an outpatients appointment on the Thursday following surgery.
  - Patients were able to self-refer to the centre for laser eye treatments. Opticians and General Practitioners (GP) would refer patients requiring cataract surgery. All patients were self-payers or through insurance. No NHS patients were treated at the centre.
- including general advice, common symptoms, pain control, problems, and how to deliver eye drops. All information booklets were clearly laid out with easy to read print.
- Patient information packs were available and included packs on laser eye and cataract surgery. The laser eye surgery patient information booklet used language that was easy to understand with pictures to describe the procedure. The risks of post-operative complications were clearly pointed out. The post-operative care booklet was very clear and included all relevant information. This meant that patients were kept well informed about all aspects of the procedures they were about to undertake.
  - For the post-operative lens surgery, the centre uses Redness, Sensitivity to light, Vision changes and Pain (RSVP) 'for the patients to remember the emergency signs of post-operative complications. Patients were signposted to call the emergency 24 hour helpline. This was an example of good practice.
  - The receptionist told us that if patients were unable to read any information booklets staff were happy to support them. Patient information was available in large font if required. Patient information was not available in other languages but translation services were available.
  - Prior to undergoing a procedure patients were given information videos, at their first consultation or sent to their home. This allowed patients to learn about their procedure in the comfort of their own home.
  - A hearing loop was available at the reception desk to support patients who were hard of hearing.
  - The building had lift access to all floors so patients with mobility issues could get safely around the centre.
  - There were toilets available for people with mobility difficulties that had hand grab rails and an emergency pull cord.

## Meeting people's individual needs

- Patient information leaflets were available for a variety of conditions including information on Implantable Contact lens and Collagen Crosslinking with Riboflavin. The information included aftercare and covered areas

## Learning from complaints and concerns

- For our detailed findings on learning from complaints and concerns, please see the responsive section of the surgery report.



# Outpatients and diagnostic imaging

## Are outpatients and diagnostic imaging services well-led?

Outstanding



We rated well-led as **outstanding**.

### Leadership and culture of service

- For our detailed findings on leadership and culture of the service, please see the well-led section of the surgery report.

### Vision and strategy for this core service

- For our detailed findings on vision and strategy, please see the well-led section of the surgery report.

### Governance, risk management and quality measurement

- For our detailed findings on governance, risk management and quality measurement please see the well-led section of the surgery report.

### Public and staff engagement

- For our detailed findings on public and staff engagement, please see the well-led section of the surgery report.

### Innovation, improvement and sustainability

- The centre's informed consent process allowed patients to develop a good understanding of the procedure before they attended the centre. Patients were given information videos followed up by a consultation and a seven day cooling off period. This allows patients to develop a good understanding of the procedure before they proceeded.

# Outstanding practice and areas for improvement

## Outstanding practice

- The service had direct access to electronic information across all three Centre for Sight centres. This meant that staff could access up-to-date information about patients, for example, details of their current medicine.
- Outcome data was presented in a way that patients could understand.
- CfSL was ISO 14001 certified which sets out the criteria for environmental management and went through an annual process of renewal. CfSL was committed to environmental management and we saw posters and receptacles encouraging staff, patients and visitors to recycle whilst at the centre.
- CfSL had a Centre for Sight Trust, which supported eye-care in developing countries. Using derived donations and charitable contributions the objectives of the trust were to develop eye care in developing countries and promote innovative eye research in the UK. The Medical Director undertook annual visits Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) in April 2015 to assess patients and perform surgical procedures.
- CfSL website also included 10 tips if patients were considering eye surgery, to find out if Laser eye surgery was right for them. It also gave information on what to consider if they were thinking of having laser eye surgery.

## Areas for improvement

### Action the provider **SHOULD** take to improve

- The provider should ensure there is an effective audit trail for prescriptions.
- The provider should review the guidelines on the use of capnography monitoring during intravenous sedation.
- The provider should ensure prescriptions are stored securely in line with NHS Protect Security of prescription guidance.