

# The London Eye Hospital

## Quality Report

29a Wimpole Street

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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?

Not sufficient evidence to rate



Are services caring?

Not sufficient evidence to rate



Are services responsive?

Good



Are services well-led?

Requires improvement



# Summary of findings

## Letter from the Chief Inspector of Hospitals

The London Eye Hospital is a private hospital that provides a range of eye treatments and surgical procedures to adults who are self-funding. They specialise in providing cataract treatment and lens implants. Their location at 29a Wimpole Street, which this report refers to, is their surgical site where all surgical procedures take place.

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? 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 regulations.

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

We rated the surgical services as good overall. However, we found that the hospital required improvement in well-led domain. It was unclear how the medical advisory committee (MAC) functioned and how consultants might play an active role within it.

We rated this hospital as good overall because:

- Staff spoke with compassion about patients. Doctors were kind and respectful towards the patient and took time to ensure they answered questions and concerns in full.
- Local management of the surgery site was robust and well-led.
- Staff told us they were confident to raise any issues with senior management. They told us the London Eye Hospital was a good place to work.
- Procedures were scheduled to accommodate patient's travel times or specific needs related to other illnesses. There was a 24 hour telephone support line available to patients.
- There was a clearly defined patient pathway. Consultants were available to patients post-operatively.
- There was a clearly defined complaints process.
- Care was delivered in line with relevant national guidelines.
- Staff had up to date training in the use of machines used at the hospital. We saw completed competencies for all staff directly employed by the provider.
- There was evidence of good internal multidisciplinary working.
- Staff understood their responsibility with regards to ensuring there was patient consent to all procedures.

However:

- There was a nine months waiting list for a particular ophthalmic procedure.
- The hospital did not have a written long term strategy.
- Clinical governance meeting minutes did not have an attendance list and there was no update on actions from the previous meeting.

# Summary of findings

- The risk register lacked consistency and detail. The incident log was not always updated to indicate how the incident was resolved.
- There was no data available to assess clinical outcomes in line with the Royal College of Ophthalmologists Cataract Surgery Guidelines September 2010.
- There was no provision for doctors to meet with each other on formal basis to share common themes.
- Two consultants' intermediate life support training was overdue at the time of our inspection. There was no record kept of consultant's competencies or any mandatory training done by them.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help it move to a higher rating. Details are at the end of the report.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

### Surgery

### Rating Summary of each main service

Good



We rated surgery as good because:

- Staff spoke with compassion about patients. Doctors were kind and respectful towards the patient and took time to ensure they answered questions and concerns in full.
- There was a clearly defined patient pathway. Consultants were available to patients post-operatively.
- Procedures were scheduled to accommodate patient's travel times or specific needs related to other illnesses. There was a 24 hour telephone support line available to patients.
- Local management of the surgery site was robust and well-led.
- There was evidence of good internal multidisciplinary working.
- Staff understood their responsibility with regards to ensuring there was patient consent to all procedures.
- Staff told us they were confident to raise any issues with senior management. They told us the London Eye Hospital was a good place to work.
- Staff had up to date training in the use of machines used at the hospital. We saw completed competencies for all staff directly employed by the provider.
- There was a clearly defined complaints process.

#### However:

- There was no data available to assess clinical outcomes in line with the Royal College of Ophthalmologists Cataract Surgery Guidelines September 2010.
- Two consultants' intermediate life support training was overdue at the time of our inspection. There was no record kept of consultant's competencies or any mandatory training done by them.
- There was a nine months waiting list for a particular ophthalmic procedure.
- The hospital did not have a written long term strategy.
- The risk register lacked consistency and detail. The incident log was not always updated to indicate how the incident was resolved.

# Summary of findings

- There was no provision for doctors to meet with each other on formal basis to share common themes.
-

# Summary of findings

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Good 

# The London Eye Hospital

**Services we looked at:**

Surgery

# Summary of this inspection

## Background to The London Eye Hospital

The London Eye Hospital is a private hospital that provides a range of eye treatments and surgical procedures to adults. They specialise in providing cataract treatment and lens implants. Their location at 29a Wimpole Street, which this report refers to, is their surgical site where all surgical procedures take place. All care and treatment provided by the hospital was paid for directly by patients. The hospital had one theatre/treatment room and a recovery area, they did not provide overnight stay and all procedures were day procedures performed under local anaesthetic. The hospital has outsourced a number of operational services to a third party provider. These included pharmacy services, clinical waste collection, cleaning / deep clean services, infection control, health and safety inspections and pathology. Patients had access to a 24 hour telephone line serviced out of hours by an external agency. In October 2015 to September 2016 the hospital performed 223 refractive

eye and cataract surgeries 423 lens implant, 26 corrections of nearsightedness, farsightedness, and/or astigmatism, 13 intravitreal injections, and 83 YAG laser procedures.

The registered manager designate was Lee Brearley. The provider's nominated individual for this service was Muhammad Qureshi.

Our inspection team was led by David Harris, Inspection Manager, Care Quality Commission. The team included CQC inspectors and specialists in the field.

We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys and audits. We placed comment boxes at the hospital before our inspection, which enabled staff and patients to provide us with their views.

We observed staff interactions with patients and reviewed patient records. We visited all the clinical areas at the hospital.



# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

**We rated safe as good because:**

- There was evidence of good learning from incidents.
- Infection prevention and control was well managed within the surgical services.
- Patients' MRSA status was confirmed before undergoing a procedure.
- Single use equipment was utilised.
- Medicines were well managed and robustly audited.
- All equipment including laser machines were regularly serviced.
- Mandatory training for employees was up to date.
- The World Health Organisation (WHO) surgical safety checklist was regularly completed and audited.

**However:**

- The provider submitted data which showed that two consultants' intermediate life support training was overdue at the time of our inspection. The provider was unable to confirm whether any consultant had advanced life support.
- There was no record kept of consultant's competencies or any mandatory training done by them.
- The incident log was not always updated to indicate how the incident was resolved.

Good



### Are services effective?

**We did not have sufficient evidence to be able to assess effectiveness of the service. The provider did not fully assess clinical outcomes and benchmark against other specialist eye care and treatment providers.**

**We noted:**

- Staff had up to date training in the use of machines used at the hospital.
- We saw completed competencies for all staff directly employed by the provider.
- There was evidence of good internal multidisciplinary working.
- Staff understood their responsibility with regards to ensuring there was patient consent to all procedures.

**However:**

Not sufficient evidence to rate



# Summary of this inspection

- There was no data available to assess clinical outcomes in line with the Royal College of Ophthalmologists Cataract Surgery Guidelines September 2010.
- There was no provision for doctors to meet with each other on formal basis to share common themes.

## Are services caring?

**We did not directly obtain views of sufficient number of patients to inform this judgement. This was due to the limited number of procedures performed at the location at the time of the inspection.**

### We noted:

- 78% of patients thought that staff were either very good or outstanding.
- Staff spoke with compassion about patients.
- We observed a patient consultation where the doctor was kind and respectful towards the patient and took time to ensure they answered questions and concerns in full.

Not sufficient evidence to rate



## Are services responsive?

**We rated responsive as good because:**

- Procedures were scheduled to accommodate patient's travel times or specific needs related to other illnesses.
- There was a 24 hour telephone support line available to patients.
- There was a clearly defined patient pathway.
- Consultants were available to patients post-operatively.
- There was a clearly defined complaints process.

### However:

- There was a nine months waiting list for a particular ophthalmic procedure.

Good



## Are services well-led?

**We rated well-led as requires improvement because:**

- The hospital did not have a written long term strategy.
- Clinical governance meeting minutes did not have an attendance list and there was no update on actions from the previous meeting.
- The risk register lacked consistency and detail.
- It was unclear how the medical advisory committee (MAC) functioned and how consultants other than the medical director might play an active role within it.

### However:

Requires improvement



# Summary of this inspection

- Local management of the surgery site was robust and well-led.
- Staff told us they were confident to raise any issues with senior management.
- Staff told us the London Eye Hospital was a good place to work.






# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Not rated	Not rated	Good	Requires improvement	Good
Overall	Good	Not rated	Not rated	Good	Requires improvement	Good

# Surgery

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

## Are surgery services safe?

Good 

### Incidents

- There were no never events reported for this service. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were a total of 38 clinical incidents between October 2015 and September 2016. Of these, 10 were deemed low harm and three were deemed to be of moderate harm to the patient. There was no pattern to these incidents, amongst which included incorrect data on patient records and poor dilation of eyes. There were no severe incidents during this period.
- We were told that all incidents were recorded as soon as possible after the incident occurred and kept in an incident log. We saw they were rated in order of severity through the use of a matrix. Any arising issues were discussed at the end of surgery and an incident form was completed.
- The lead nurse told us they sent an end of day report to the registered manager on each surgery day, which included any arising issues. These were then discussed at departmental meetings and in addition, the hospital manager summarised them in order to identify any emerging trends.
- We looked at the incident log and saw that whilst there was a paper record of incidents, the log was not always updated about how the incident was resolved. For example, where a patient was required to self-report on their MRSA status, there was no update on the incident as to whether this had happened. We discussed this with a member of staff who confirmed that the procedure had gone ahead following a negative result for active MRSA. They acknowledged that the incident record should have been updated to reflect this and then be closed.
- We spoke with staff about their learning from incidents and they could give us a range of examples and resultant changes to practice. For example, not all patients with blood pressure problems were detected at their assessment which resulted in their procedure being cancelled. A new policy and protocol was introduced, which enabled staff to interpret blood pressure readings and ensure they were within normal parameters for surgery. This resulted in significantly fewer procedures being cancelled.
- Another incident recorded was where the salbutamol on the resuscitation trolley was almost out of date (medication that opens up the medium and large airways in the lungs). The drug was reordered from the pharmacist but they had none in stock. The drug was delivered just before the use by date on the original salbutamol came into effect. This resulted in a more robust stock and order form, which logged quantities in stock, use by dates and dates by which the stock must be ordered. The hospital manager told us there had been no further such recurrence.
- We were told of a time when a patient did not reveal their allergy to latex, despite the fact that there were several opportunities during the course of their assessment and patient journey to clarify this. This was

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discovered during their procedure and immediate measures were taken to mitigate against this. The outcome of this was that the health questionnaire was amended to include a specific question about a patient's reaction to latex.

- We saw one recorded incident in September which related to unsafe humidity levels in theatre which posed a potential infection risk. The registered manager confirmed the actions taken included employing extra dehumidifiers. Additionally, those patients whose procedure was cancelled were rebooked for a suitable date and compensated for all out of pocket expenses.
- Humidity levels were monitored throughout the day and when they returned to within normal range the theatre was cleaned and equipment calibrated. The team returned early next day to check that all levels were safe and the consultant was happy to continue to treat patients.
- The registered manager said there was no formal mortality and morbidity meeting and any related incidents would be discussed at the monthly departmental meeting.
- The duty of candour (DoC) 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. Staff we spoke with understood the meaning of DoC and told us the clinical director or registered manager would take responsibility for speaking with patients or family. They could not recall a time when DoC was performed.

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

- The hospital did not have a clinical quality dashboard. The registered manager told us they monitored safety through their risk register which was discussed at monthly departmental meetings. We saw that those patients considered to be at risk had a falls risk assessment recorded on their patient pathway. Recurrent themes were noted and actions taken, for example where a new blood pressure protocol was introduced.

## Cleanliness, infection control and hygiene

- Infection prevention and control (IPC) was well managed within the surgical services. The clinical areas we visited were visibly clean, tidy, well organised and clutter-free. Whilst there were no patients booked in for surgical procedures, we observed staff washing their hands and using hand gel as they moved around the premises and they were compliant with the 'bare below the elbows' policy.
- All sinks in patient areas had posters of 'hand washing technique' displayed. We witnessed staff using a good hand washing technique which was compliant with the Health Protection Agency (HPA) guidelines.
- Hand hygiene audits were initiated in July 2016 to be carried out every four months by the nurse in charge. Audit results for July and November demonstrated the surgical services were compliant with hand hygiene. Recommended actions included posters explaining indications for hand hygiene, the correct use of hand rub, proper hand washing technique and the availability of hand cream at points of care. We saw these recommendations had been put into place.
- There had been no cases of methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile for the 12 months prior to the inspection.
- Patients with MRSA were not treated. The health questionnaire asked whether they had ever had, or had any doubt about having MRSA. If so, they were requested to have a nasal swab at their GP practice. They then needed to submit the results before surgery could go ahead. We saw on a patient's record that their surgery had been deferred pending this test being carried out at their GP. We subsequently saw written confirmation on their record that this patient was cleared for surgery four weeks later.
- Single use equipment such as irrigation and aspiration handles was used in theatre. Where equipment was not disposable, this was sent to an off-site external contractor to be sterilised. The hospital outsourced all sterilisation of reusable medical devices and clinical waste collection. Staff told us this service was efficient and reliable. We saw that the area where clinical waste was stored before collection was orderly and well maintained.

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- There were no surgical site infections recorded or incidents of post-operative endophthalmitis (an inflammatory condition of the intraocular cavities) between October 2015 and November 2016.
- The curtain around the bed where patients were anaesthetised had a change date of August 2016, and we were told they were replaced every six months.
- A legionella audit carried out by an external contractor in August 2016 confirmed that there was no legionella pneumophila detected.

## Environment and equipment

- Staff had an understanding of the equipment they used and were competent to deal with minor malfunctions related to these machines, for example, the microscope pseudophakic machine. All operational issues related to laser machines were addressed by the machine manufacturer and we were told they responded quickly to repair requests, usually within a matter of hours.
- There was a resuscitation trolley available in the minor surgery and anaesthetic room, which also included difficult airway equipment. We saw from the log book that the trolley was checked on a monthly basis, with no omissions. It was secured with a single use tag. We checked the contents and confirmed that all stock was present and in-date. The nurse in charge secured the trolley following our check.
- There was one defibrillator machine, which was checked on all surgery days. We saw the log book with print notes and a sticker which indicated that it had been tested recently. We were told that if the machine malfunctioned, engineers responded very quickly to a call-out. However, in the event of the machine failing, the anaesthetic machine in theatre, which had an in-built defibrillator, would be used as a back-up.
- Single use equipment such as syringes, needles, oxygen masks and suction tubes were readily available and stored in an organised, efficient manner in the anaesthetic and recovery rooms.
- We noted there was no sign on the theatre door to indicate when surgery was in progress. The nurse in charge acknowledged that there was a possibility other

staff could enter the theatre during surgery and either contaminate the aseptic area or disturb the procedure in progress. They told us they would bring it to the attention of the registered manager.

- Equipment in theatre was up to date and portable appliance tested according to regulation. Data submitted by the provider evidenced that there were maintenance contracts for all equipment and all had been appropriately tested and where relevant, calibrated. We saw that a full equipment list was maintained which included PAT testing dates.
- The hospital provided safety goggles with varying levels of protection that were designed for the lasers being used. Eye caps were also available to protect the eye not undergoing a procedure.
- The theatre department used four different types of laser machines each of which were of a different strength and had a different method of delivery. There were colour coded goggles to identify which machine these were used for. We saw a matrix which indicated that staff were authorised to use some or all laser machines. The registered manager told us consultants were authorised to only use lasers which directly related to the procedures they carried out at the hospital.
- The pre and post-operative area was compact and had four cubicles with curtains around each of them. All seating was covered in a wipe clean material and was in good repair. A member of staff told us that patients who required an additional level of privacy were taken into the anaesthetic room. Patient attendance was planned in such a way that there was never a need for more than the four cubicles.
- We saw a recent site maintenance report for the ventilation and air-conditioning systems carried out by the external contractor. There were no concerns reported.

## Medicines

- Medicines were appropriately stored in a locked cabinet and the keys were held by the nurse in charge.
- All additional supplies were kept in a locked storage cabinet, rotated in date order and checked on a regular basis. We were told by a member of staff that they took

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responsibility for reordering stock, which they did on a monthly basis, in order to ensure stocks did not run out. Out of date or unwanted drugs were returned to the local pharmacy for disposal.

- We were told that nurses did not prescribe medicines as this was done by the surgeon. The patient pathway record included a prescription chart; we saw charts were signed by the operating surgeon. Staff explained to us that the patient left with a copy of this prescription.
- We saw staff competencies for administering medicines were up to date and held on the staff member's training record.
- Controlled drugs were kept in a separate locked cabinet with a record book for double signatures, in line with controlled drugs policy. We saw from the record log that they were checked daily. Staff were able to tell us the procedure for their safe storage and record keeping.
- We did a spot check of stored medicines and equipment in the anaesthetic room and found that there was a plentiful supply of both, all within the appropriate expiry date.
- Fridge temperature checks were carried out at the same time each day and we saw there were no omissions in the log book we looked at. All were found to be within the recommended temperature range. There was a protocol attached to the record log which made it clear what steps should be taken if the temperature was out of range. This included who to escalate the problem to, where to move drugs to, or which drugs would need to be disposed of.
- The sharps bins in theatre and pre-op area were appropriately labelled and with sufficient storage space remaining.
- We noted that the only copy of the British National Formulary (BNF) in the building was out of date (2012). The BNF is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about many medicines available within the UK National Health Service (NHS). A member of staff acknowledged that since it was so out of date, its usefulness as a quick reference was limited and therefore an up to date copy would be placed on order.
- We looked at four samples of medical and nursing records for those patients undergoing a procedure. The hospital used mainly a paper based record system for recording care, treatment and surgical interventions. Each had a patient assessment and treatment record booklet (care pathway) for all surgical patients which was used throughout their time at the hospital. We saw that nursing and medical records were accurate, fit for purpose, stored securely and were mostly completed to a good standard.
- We saw that a sample of 10 sets of patient records was audited every month. We looked at audits for the six months prior to this inspection and saw the majority were completed to a high standard. There were some comments made by the auditor; for example, on one record, it was commented that a blue pen had been used instead of a black one. On another, some writing was scribbled out, rather than crossed out with a double line as per the hospital's guidelines. The auditor added a note which stated that the crossed out wording was rewritten on the patient pathway.
- The patient pathway booklet had been designed to ensure all peri and post-operative information was kept in one place. This consisted of patient medical history, pre-assessment information, risk assessments, admission information, theatre checklist, observations, recovery and discharge information.
- Pre-operative assessments took place within the out-patients department (OPD), which was located close by, at a different location. An optometrist took the patient's history and did all relevant tests, including diagnostic imaging. Following an initial meeting with a consultant on this same day, the patient was then given a date for their surgery.
- The risk register included an incident where patient notes were not transferred from OPD to the theatre site, resulting in the procedure being delayed. The harm to the patient was rated as negligible. We asked a consultant about the transfer of patient notes between sites, and were told this was not an issue; the sites were a six minute walk from each other and in the majority of cases, the notes were already on site in time for surgery.
- We were told that the hospital abided by the guidelines with regards to venous thromboembolism (VTE) and all patients were assessed accordingly.

## Records



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- Patient details were registered on an electronic system. This enabled a smooth transfer of patient details between OPD and theatre. Patient notes were scanned onto this system once they return to OPD for a check-up.

## Safeguarding

- There was a safeguarding vulnerable adults policy and a safeguarding children policy both of which gave guidance to staff as to signs to watch for as well as the process for reporting concerns.
- All medical, nursing and support staff were required to undertake annual training in the safeguarding of vulnerable adults which was part of the mandatory training package. Staff knew where to find information should they need to. We saw training records that confirmed all staff in theatre services had completed safeguarding adults and safeguarding children training.
- We saw from the staff training matrix that all staff had completed levels 1&2 safeguarding children training. Staff explained that whilst the hospital did not treat anyone under 18 years old, there were occasions when children accompanied a family member; therefore it was felt necessary to be aware of safeguarding for children.
- Safeguarding training for staff was delivered during face to face sessions. Staff we spoke with were able to tell us how they would report any safeguarding concerns in line with the provider's policy. They understood that the local authority would take the lead in any necessary investigations.

## Mandatory training

- Mandatory training included basic life support, Mental Capacity Act 2005 and infection control, as well as health and safety, information governance, fire safety and complaints handling and conflict management. In addition, two people were trained as fire marshals and first aiders. We were told that staff were given time off or time in lieu for their training.
- The staff training matrix logged mandatory training completed by some staff employed by the provider but it did not include any training completed by consultants. From the training matrix provided, we were able to see that all staff listed were up to date with their mandatory

training. Staff said they considered the training, which was a mix of face to face and e-learning, to be of a good standard and equipped them to do their jobs to the best of their ability.

- However, the registered manager told us there was no record kept of any training which practising consultants had completed. We were told that all but one consultant practised within the NHS and therefore there was an assumption that they were up to date with mandatory training. They acknowledged that since there was no evidence on record to evidence this, it was necessary to ensure all consultants completed the provider's mandatory training.

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

- All patients attending the London Eye Hospital were self-funded. They contacted the hospital directly to book a consultation. During appointments with a consultant patients were told whether the hospital could offer them a service. We observed one consultation where the patient was told the hospital could not offer any support to address their particular eye condition since the damage was too great. However, the consultant offered advice about treatment at a later date on the other eye.
- Patients had their blood pressure, pulse and oxygen saturation levels recorded immediately prior to their surgery. This was repeated post-surgery whilst the patient was in recovery. We saw these observations were recorded on all of the patient records that we reviewed.
- The patient pathway included an assessment of a patient's risk of falls. If this was deemed to be a risk, we saw where the person taking the history was directed to a fall risk form, which they had to complete. Other risk assessments included skin integrity and blood pressure levels. No procedure was performed under general anaesthetic.
- The World Health Organisation (WHO) surgical safety checklist was developed to help decrease errors and adverse events, and increase teamwork and communication in surgery. It has five steps which include briefing, sign in, time out, sign out, and debriefing. T

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- The provider had separate WHO checklists for cataract surgery and laser eye surgery. We looked at audits between May and November 2016 of the WHO checklist and saw there were no omissions recorded.
- The checklist were documented on each patient's care pathway. This included needles and swabs sign in and out. We saw that steps one and five were written separately on the team brief and debrief. We reviewed records of the team brief and debrief for the previous three months. One note that had been made was to request that the debrief did not start until the recovery nurse was free to attend. We were told that there had been occasions when the debrief had felt rushed and was sometimes done before all staff were free to attend. This was no longer the case; we saw from the attendance list of the previous three months that all those who had been involved in the procedure were present for the debrief.
- We noted that whilst details of a procedure were recorded directly on to the patient care pathway as they occurred, there was no specific patient board in theatre to record details, for example, which eye was being operated on, which lens was being implanted and a count of equipment used.
- It was noted that on one patient record, the anaesthetist had not signed their part of the patient pathway. We asked how this had been addressed with the anaesthetist and were told that the hospital manager had discussed this error with them. We did not see any recurrence of this problem in subsequent audits.
- We were told that the hospital did not offer a service to high risk patients. In the event of a deteriorating patient, staff would immediately call for an ambulance, whilst at the same time attempt to stabilise the patient.
- The lead nurse had basic life support training and could show us documentation to verify that they were attending an intermediate life support course in the week after this inspection.
- We were sent data which confirmed that two consultants had out of date intermediate life support training (ILS) at the time of our inspection. We were told that these consultants were booked on to a course in January 2017.

- However, the provider was unable to provide evidence to confirm whether any consultant was trained in advanced life support.

## Nursing and support staffing

- There was no formal clinical supervision for the lead nurse who told us they felt confident to discuss points of learning with any of the consultants, including the medical director. They also said they used a nurse forum in the Royal College of Nursing for a level of peer support and learning.
- Staffing levels across the surgical service were sufficient to deliver safe patient care. Vacancies and absences through sickness were managed with regular bank or agency staff. We were told that bank staff numbers were being increased but there were occasions when agency staff had to be employed. The number of staff on duty at any one time was calculated according to the service being provided and the registered manager was responsible for ensuring adequate staffing levels to support skilled safe care. We were shown an analysis of staffing requirements for specific procedures carried out at the hospital and were told that in almost all cases, the recommended levels were maintained.
- We were told that on surgery days, there was one permanent nurse, one bank nurse and one health care assistant (HCA) present. One nurse covered pre-operative patient preparation and discharge whilst the other nurse acted as a scrub nurse. The HCA told us they circulated in theatre or assisted with patient preparation as necessary.
- We were shown a breakdown of staffing levels between June and November 2016 and saw that there were two nurses on duty on theatre days for all but one day during this period. At times when the HCA was not on duty, we saw that they were replaced by a bank nurse, which meant there were occasions when there were three nurses covering on the day.
- A second nurse was employed in September 2016 and the staffing matrix showed that there were three nurses on duty over a period of weeks which meant the new nurse was supernumerary during their induction period. However, this nurse had recently left. A member of staff

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explained that a replacement was necessary as there were occasions when they felt they were not able to give the patient enough time following their procedure to chat and reassure them.

- They told us how an extra member of staff was required to assist with patient circulation, ensuring effective patient flow and sufficient time to do pre and post-operative patient safety measures and checks. They told us they had raised this with the registered manager and the medical director and were confident that the situation would be addressed.
- Staff acknowledged that it was important to get the right skill mix for the team rather than to employ a person just to make up numbers. We discussed this with the registered manager who told us it was understood that the workload had increased dramatically as a result of a new development in a particular type of lens. We were told that an increase in staffing had been agreed by the medical director and an additional nurse post had been advertised, with interviews booked for the following week.

## Medical staffing

- All consultants who practiced at the hospital were assessed by the hospital's medical advisory committee (MAC) prior to being given practising privileges. They worked as individual practitioners and were not employed by the London Eye Hospital. At the time of our inspection there were six practising consultants, which included the owner/medical director.
- The registered manager told us that individual doctors were responsible for their own training and ensuring their skills were in line with the procedures they performed. Training and skills were confirmed through the GMC revalidation process and this revalidation was submitted to the registered manager and the medical director.
- However, we were told there was no record kept of training or competency levels of any consultant. The medical director was directly responsible for deciding whether a consultant was competent.
- The registered manager told us that consultants had to be available and easily contactable for patients following their discharge for at least 48 hours and longer if required. On occasions when a patient contacted the

hospital with post discharge discomfort or concerns, hospital staff contacted the consultant for advice. We saw e-mail evidence that response rates from consultants were quick, and in most cases they responded within an hour.

- Patients were seen on an outpatient basis. The hospital used a 24 hour telephone answering service to respond to patient calls. The on-call person for the hospital, usually the registered manager or the Finance Director, then spoke with the patient. If there was a medically related issue they would contact the operating consultant.

## Emergency awareness and training

- The hospital did not have a major incident plan. The registered manager told us the provider's fire and evacuation plan included actions to be taken in the event of a mass evacuation of the building. We were told that the majority of patients were mobile and since none were treated under general anaesthetic, they would be assisted from the building by a member of staff to the assembly point. In the meantime, if the electricity failed, there was a back-up generator on the laser machine, which enabled the procedure to be completed.
- We saw a copy of the hospital annual fire risk assessment which was undertaken during January 2016. The auditor highlighted actions which the provider should take, which included refresher training for the fire marshal, weekly fire alarm testing and monthly testing of the emergency lighting.
- The hospital manager told us these actions had since been addressed. We looked at the fire safety file which included evidence of regular checks on fire extinguishers, weekly checks on fire alarms and fire detection equipment and monthly checks of emergency lighting. There were no omissions in the records we looked at from February 2016. We also saw an up to date refresher training certificate for the appointed fire marshal.

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## Are surgery services effective?

Not sufficient evidence to rate 

### Evidence-based care and treatment

- Due to the single speciality nature of the hospital, many national audits were not relevant and therefore the hospital did not take part in national audits. The registered manager told us patient clinical outcomes were audited in line with The Royal College of Ophthalmologists Cataract Surgery Guidelines September 2010 however; there was no available data to confirm this.

### Pain relief

- We were advised that most ophthalmic procedures caused little or no pain. Nurses discussed pain relief with patients during pre-assessment and provided information on types of pain relief that patients could expect to receive as part of their procedure. Pain was assessed post-operatively and analgesia administered as required.

### Nutrition and hydration

- Staff told us that consideration was given when scheduling patients with diabetes to enable them to have sufficient food intake prior to their procedure. Pre and post-operative snacks were available to all patients if required.

### Patient outcomes

- Outcomes of refractive procedures were measured against the Royal College of Ophthalmologists Cataract Surgery Guidelines September 2010. The registered manager told us audit results were presented to the medical advisory committee (MAC) and disseminated to the individual surgeons. We saw no evidence of this in the MAC minutes we reviewed.
- The hospital showed us results of a recently completed audit for their newly developed lens. This was of a sample of 61 patients and showed significant improvements in near and distance vision. These results could not be benchmarked because this lens was an innovation, developed by the hospital and not yet in the public domain.

- The hospital carried out a patient survey and 70% of patients who had undergone a procedure at the hospital were satisfied with the outcome of it. 65% of respondents felt that their surgery day was very good or outstanding.
- There were no unscheduled patient returns to hospital across all treatments between October 2015 and November 2016.
- The London Eye Hospital sees patients on an outpatient basis only. Therefore, they currently do not have to submit data in accordance with legal requirements regulated by the Competition Markets Authority (CMA). The provider return stated that this was confirmed with the Private Healthcare Information Network (PHIN).

### Competent Staff

- Competency log books for each piece of equipment indicated that consultants were competent in the use of that equipment. We were shown an independent site audit which recommended that one particular surgeon required core knowledge training. We were told by the registered manager that this was in relation to a specific machine which that surgeon never used as it was not part of their operating duties for the hospital.
- We were told that once a member of staff had been trained on any machine, they did not usually refresh this training.
- We saw staff competency records completed on the use of the blood pressure assessment tool. This was developed to support staff in the recognition of the parameters within which it was safe for patients to have surgery. We spoke with a member of staff who was able to tell us why this assessment tool was initiated and gave us a comprehensive explanation of each step of the process.
- The lead nurse assessed competencies of new staff, including bank staff. We were told that if there was a need to employ a nurse from an agency, the agency was responsible for ensuring the nurse was competent. They said the hospital used one specific recruitment agency which was aware of the London Eye Hospital's standards and expectations.
- We saw completed competencies on staff training records for medicine administration, including instilling eye drops. One member of staff we spoke with told us

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the training they received was comprehensive and gave them confidence to administer eye drops. They were able to tell us about their role in relation to the provider's medicine management policy and were very clear that there were certain drugs which only the registered nurse could administer.

- Staff told us that the lead nurse continued to support them in all aspects of medicine administration and ensured that high standards were maintained. We also saw competency assessments for the international normalised ratio (INR). This is a measure of the length of time it takes blood to clot. INR results are used to determine the patient's required dose of a blood clotting drug.
- The lead nurse attended a recent international ophthalmology conference funded by the provider.
- Staff told us they were appraised annually and records confirmed it.

## Multidisciplinary working

- We observed healthcare assistants, nurses and doctors communicating well with each other to ensure safe and effective care.
- One of the consultants had agreed to provide a training session on diagnostics for theatre staff which we saw was scheduled for shortly after our inspection.
- A doctor told us there was good teamwork with the other doctors in the hospital. They told us they would ask doctors from other specialties for support if a patient presented with multiple needs.
- There was a departmental meeting held each month. This included staff across both sites, led by the registered manager and hospital manager.
- However, there was no provision for doctors to meet with each other on any formal basis to share common themes.

## Access to information

- Staff had access to an electronic system, which provided live tracking data throughout the patient's surgical pathway. This was particularly helpful since patients had their initial assessment on a nearby site and their progress could be monitored by staff on the surgical site.

- Staff told us policies were available on the hospital intranet and demonstrated how to access these. Computers were readily available for staff to access.
- We saw that GPs were sent patient discharge letters outlining the procedure their patient had undergone.

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

- Mental Capacity Act 2005 (MCA) training was mandatory for all staff and the training matrix showed that there was 100% compliance.
- Staff we spoke with demonstrated an understanding of the requirements of the MCA. They told us they continued to ensure they had patient consent for all interactions during the patient's time at the hospital.
- A consent form was sent to the patient's home for them to consider prior to their procedure. Staff told us this gave people time to consider their options in the privacy of their home without any question of feeling pressured into making a decision. The patient then signed the consent form on the day of their procedure, once all aspects of the treatment were once again explained to them.
- We spoke with staff about how they knew patients had capacity to consent to a procedure. We were told that any concerns about patient capacity would be flagged up in the health questionnaire. This matter would then be raised with the patient and their family when they came to the hospital. The surgeon would be informed of any doubts about the patient's ability to consent and they would spend time with the patient, and where relevant, their family. This was in order to be assured that the patient had a good understanding of the procedure and was happy to give consent.
- A doctor told us they had suggested some amendments to how consent was documented on patient notes. They wanted to be satisfied that a patient was aware of all associated risks. As a result, changes were made which included the addition of 'risks explained' on the consent form. We saw this listed risks specific to the type of procedure.

Are surgery services caring?



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Not sufficient evidence to rate 

## Compassionate care

- The hospital initiated a survey in May 2016 to establish a variety of trends; this included how to maximise business and establish which patients were the most satisfied so as to build up case studies with a view to posting them on line. There was a 39% response rate from patients who had a consultation only in 2016 and 18% response rate from patients who received treatment in 2014-15.
- 93% of respondents felt they had received good or outstanding information to prepare them for surgery. A recommendation made by the hospital in response to the 7% who rated information as poor or fair was that the patient journey should be reviewed in order to improve information delivery to patients in advance of their surgery day.
- 72% of respondents felt that staff were very good or outstanding when disseminating information to patients prior to leaving the hospital.
- 78% of respondents thought that staff were either very good or outstanding when it came to being courteous, polite, friendly and helpful.
- 54% of patients said they would definitely recommend the hospital to family or friends. The hospital's response to this was that the consultation stage should be more robust. It should highlight possible risks, make shared decisions with patients and be realistic about possible results.
- Patient privacy and dignity was maintained by the use of curtains around cubicles in the preparation and recovery area.

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

- There were no surgical procedures scheduled during this inspection which meant that we were unable to speak with any patients. However, we observed a consultation with a patient who had previously received treatment at the clinic.

- The patient did not speak English and had a family member with them to act as interpreter. The doctor addressed all of their questions and comments directly back to the patient and gave plenty of time for their relative to translate. They checked with the family member that the patient understood all aspects of the procedure being discussed before continuing with the consultation.
- The patient later told us via their relative that they had fully understood the consultation discussion and felt wholly included and respected by the doctor.

## Emotional support

- Staff spoke with compassion about the patients who came to the hospital and told us they prioritised patient comfort. They said they wanted patients to have the best possible experience. A consultant we spoke with told us where they were unable to offer help to a patient, they endeavoured to signpost them to other places where they could be assisted. They told us they made sure the patient heard what was likely to be disappointing, and at times, upsetting news. They said they did this as sensitively as possible, whilst being factual and clear in their delivery.

## Are surgery services responsive?

Good 

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

- The hospital had many patients who had travelled long distances and often from abroad. This was taken into consideration when their procedures were booked. We were told that there was usually a maximum of five procedures booked in during the morning and five in the afternoon. These were staggered in order to ensure there was sufficient room in the pre-operative and discharge area.
- Patients had access to a 24 hour telephone line. This was serviced out of hours by an external agency which messaged the on-call responsible person at the hospital, who in turn contacted the relevant consultant and informed them of the patient's need to be contacted by them.

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- Leaflets about different types of eye conditions and treatments were available to patients. We were told these would be made available in large print if requested.

## Access and flow

- The lead nurse told us they began the patient pathway when they reviewed patient health questionnaires one week in advance of their booked surgery. Any concerns, changes or potential complications in the patient's condition were picked up at this stage. The patients received a pre-operative courtesy telephone call from a health care assistant to confirm their fitness for surgery and to note any possible change to their condition. If any concerns were raised, the nurse would speak with the patient and if necessary, postpone the procedure until the issue was resolved.
- Any patient related matters detected on the day of surgery were highlighted to the surgery team as part of the briefing prior to surgery.
- The patient received a post-operative telephone call from either the nurse or HCA. Any issues of concern which were raised were e-mailed to the relevant consultant. We saw several such e-mails to consultants and noted that on all occasions, a reply was received within a matter of hours at most. These replies included either simple advice to be relayed to the patient or, where there was a matter of greater concern to the patient, the consultant confirmed that they would speak directly with the patient.
- Upon discharge, the patient's GP was sent a letter with information on the procedure their patient had undergone. A doctor gave an example of where they raised a concern with a GP about a health related matter they had detected within a patient during a consultation.
- The hospital cancelled 40 procedures for a non-clinical reason between October 2015 and September 2016 and all 40 were rebooked within 28 days. We were told that the majority of these cancellations were in relation to the introduction of a newly developed lens. The medical director took the decision to discontinue the use of the previous lens and so patients had their procedure rescheduled to accommodate the arrival of the new lens.

- The registered manager told us there was a waiting list of six months, though records we looked at indicated that the wait was nine months. They attributed this to the increased demand for the new lens which the current provision of consultants could not meet. We were told that the hospital was actively recruiting new consultants to address this situation and meet the demands of the waiting list.

## Meeting people's individual needs

- Staff told us it was important to anticipate any potential difficulties in order to ensure a good patient experience. For example, where a patient had Parkinson's disease, their procedure was scheduled for shortly after they had taken their medication; this meant their involuntary body movements were reduced which enabled a safer procedure to be performed. They also tried to anticipate communication or language difficulties by ensuring there was a family member to translate for the patient or if necessary to engage the services of an interpreter.
- Where a patient's first language was not English, we were told that most patients took along a family member to translate on their behalf. In such circumstances, the family member could accompany the patient in to theatre to ensure complete understanding of what was going on. The clinic could also access a translation telephone line in the absence of a family member, although staff we spoke with could not recollect an occasion when they had needed to do this.

## Learning from complaints and concerns

- The hospital received 38 complaints between December 2015 and September 2016 (related to both locations managed by the provider); 12 of these were where the patient did not notice the functional benefit of treatment, and five were not happy with results post-surgery. There were 10 open complaints, three of which were due to the patient not noticing the functional benefit of treatment and two had no change in vision post treatment. Two of those who did not notice any benefit were offered an exchange of intraocular lens, and those that had no change to their vision continued to be monitored.

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- Patients were issued with a complaints booklet which explained the process. They were also given a comments card on which to write any complaints or comments.
- The patient guide and statement of purpose contained information on how to make a complaint and who to complain to. The complaints procedure had recently been updated. The policy stated that written complaints would be dealt with in a timely manner. The registered manager acknowledged receipt of the complaint in writing within two working days. The complaint would be investigated and a written response provided within 20 working days of receipt of the complaint.
- Where the investigation was still in progress, the registered manager would send a letter explaining the reason for the delay within the 20 days of receipt of the complaint. A full response was sent within five working days of a conclusion being reached.
- All staff received complaint handling and conflict management as part of their mandatory training. They were encouraged to resolve any complaints at the point of contact. If a patient was not satisfied with the response they received, they could follow the complaints procedure and write to the registered manager.
- The complaints log evidenced that complaints were responded to in line with the provider's complaints policy.

## Are surgery services well-led?

Requires improvement 

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

- The London Eye Hospital was owned by the medical director. The registered manager was in charge of both surgical services and outpatients. On-site surgical services were led by a hospital manager and a lead nurse. The registered manager and the hospital manager were non-clinical.
- Staff we spoke with expressed pride and commitment to their work. They told us they felt confident to raise any issues with the hospital manager and the registered

manager. One member of staff told us they did not hesitate to query something with a consultant if it was a change from the norm, for example a different type of eye drop used.

- A consultant we spoke with told us the medical director was very supportive, accessible by telephone and available to give guidance about complex patients.

### Vision and strategy for this this core service

- There was no formal written vision or long term strategy for this service.
- Staff told us their vision for the service was to continue to offer patients life changing procedures in a safe and innovative environment.

### Governance, risk management and quality measurement

- Clinical governance meetings were held every three months. We looked at the meeting minutes which included new implementations, audits, health & safety, administration and patient satisfaction. We noted that attendees were not listed, and there was no update on actions from the previous meeting.
- Registered risks did not always specify which site they referred to and did not have dates by which actions were completed or by whom. There was also inconsistency with regards to the occurrences which were listed as a risk. For example, there was an issue in August 2016 with raised humidity levels in theatre. This was not listed on the risk register for August, whereas occurrences such as a fused light bulb and wet entrance steps to the OPD site were logged.
- We saw copies of risk registers for August, September and October 2016. All risks were rated as minor and most were related to environmental risks. Those which were patient related included the incorrect date of birth and wrong lens recorded on patient notes. Corrective actions taken were noted on the risk register. However, there was no name or date against them with regards to who had completed the action or whether the registered manager had signed it off.
- The role of the medical advisory committee (MAC) was to be the formal organisational structure that ensures clinical services, procedures or interventions were provided by competent medical practitioners. We were



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told that the MAC met every six months and was attended by the medical director/owner, registered manager, lead nurse and hospital manager. We asked whether any of the practising consultants attended on a regular basis. We were told that other consultants would be invited to attend if there was a matter arising which directly related to them. The registered manager could not recall any time when a consultant was invited along to the MAC meeting and so it was unclear to us how other consultants made their views known, or how they contributed to the work and oversight of the MAC.

- We saw a copy of the minutes of the most recent MAC meeting from August 2016. It was noted that the practicing privileges of two consultants were due for review in November 2016 and January 2017. The only note made of the discussion around their continuation was 'no concerns noted' for one consultant and for the other, 'all expressed what a great consultant they were.' The continuation of their practicing privileges was then confirmed. There was no other evidence available to inspectors to evidence how this conclusion was reached, for example, no record of a formal appraisal.

## Public and staff engagement

- Staff told us there was an opportunity during the monthly departmental meetings to discuss improvements in the patient's journey, improve understanding and to work together to improve the overall patient experience.
- The registered manager told us patient feedback and comments were actively encouraged at all points of the patient pathway.
- There was publicly displayed information on different types of eye conditions and available treatments.

## Innovation, improvement and sustainability

- We were told that the medical director who was also the owner was constantly striving to develop better provision for patients. One of the outcomes of this was a new type of intraocular lens to treat macular degeneration which was introduced in February 2016. Whilst this intraocular lens is specific to the hospital and so there is no national benchmark, evidence gathered by the hospital suggested that the results from this lens were very positive.

# Outstanding practice and areas for improvement

## Areas for improvement

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

- The provider must maintain robust records of consultants' competency levels and all completed mandatory training and ensure all staff completed relevant training.
- The provider must ensure that there is an up to date copy of the British National Formulary (BNF) available to staff.
- The provider must develop a quality monitoring system to allow assessing its clinical performance and patients outcomes.

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

- The provider should facilitate clinical supervision for the lead nurse.
- The provider should make clinical governance meeting minutes more robust with an audit trail of completed actions.
- The provider should review the way in which the medical advisory committee (MAC) currently operates and consider a more inclusive approach.