Optegra Surrey Eye Hospital

Quality Report

10 Alan Turning Road
The Surrey Research Park
Guildford Surrey
GU2 7YF
Tel:01483 903004
Website: www.optegra.com

Date of inspection visit: 3rd October 2017
Date of publication: 16/02/2018

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Optegra Surrey Eye Hospital is part of a nationwide company, Optegra UK Limited. The hospital has no inpatient beds but provides an ophthalmic surgery and outpatient service. Facilities include one ophthalmic operating theatre, one laser refractive theatre, outpatient and diagnostic facilities. The hospital provides services to adults only

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 3 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.

Summary of findings

The services provided at this hospital included ophthalmic disease management, refractive eye surgery, oculoplastic, retinal diagnostic and general surgical services. The surgery and outpatient services worked closely together with staff working between departments. 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.

Services we rate

We rated this service as Good overall because

- Openness and transparency about safety was encouraged. We observed a positive approach in theatre to completion of the safe surgery checklist in line with World health organisation (WHO) 'Five steps to safer surgery'. Comprehensive auditing and a culture of "No WHO, no operation' ensured all staff were engaged with the process.
- The hospital maintained standards of cleanliness and hygiene. We observed environment to be visibly clean and tidy with good use of personal protective equipment and good hand hygiene practices throughout the hospital.
- The hospital had developed a safe staffing policy and had a locally developed tool used to ensure staffing was appropriate across the hospital.
- There was a comprehensive annual audit plan and we saw that the results were discussed at staff meetings and areas for improvement were identified and actioned.
- Staff we spoke to had completed an appraisal and told us that the appraisal process was of value.
- There were processes to gain consent that were in line with legislation and guidance. The process for seeking consent was monitored.
- Staff routinely collected information about people's care, treatment and outcome. The hospital had access to an eye science department, whose role was to collate outcome data and for all consultants. All Consultants had access to their data. Each quarter this outcome data was benchmarked across the business.
- Staff monitored laser protection processes and we saw the laser protection supervisors were up to date with training.
- Patients told us they were well looked after and that the staff were caring and kind. We observed positive interactions by staff and that patients were cared for in a professional and compassionate way throughout the hospital
- The development of a patient liaison role focussed on giving the patient a constant point of contact throughout their stay and supported continuity of care.
- There was flexibility in the planning and delivery of services which met the patient needs. There was flexible management of theatre operating time and clinics.
- There was no waiting list of patients for refractive eye surgery. There were no breaches of the 18 week pathway recorded for NHS patients.
- The service recognised that patients had individual needs and might need support with communication and were able to provide assistance in hearing and translation.
- There was clear patient information on how to make a complaint and complaints received were managed in line with policy. Learning from complaints was shared with staff.
- There were clear lines of management responsibility and staff knew who their line managers were and spoke of their managers as being approachable and supportive.
- There were corporate values and a statement of purpose which was displayed around the hospital
- The hospital undertook a caring, responsive, effective, well led, safe (CREWS) audit on a regular basis which measured the readiness of the hospital to receive patients in line with the safety and compliance.
- There was a comprehensive integrated governance structure in place.

Summary of findings

- Active staff engagement included open communication and a staff recognition scheme.The annual colleague engagement programme showed staff engagement to be very good.
- Patient feedback was collected and results were acted on with a focus on learning and improving services.

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

- We identified concerns in relation to a lack of policies and staff competencies around dispensing and labelling of medicines. Eye drops were administered before the correct operative site had been marked which would increase the risk of an error occurring.
- In theatres, staff explained that medicines were prepared for dispensing before the doctor had prescribed them. This meant that there was a risk if the prescribed medicines deviated from the ones normally prescribed this might go unnoticed.
- There were no competency documents for Healthcare Technicians to ensure that staff had adequate skills and knowledge to care for patients.
- The anaesthetic machine in theatre was not checked on a daily basis. Staff told us the machine was not used, in which case it should been taken out of use or checked in line with guidance.
- There was no capnography monitoring available for use during sedation in line with guidance. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommendations for Standards of Monitoring during Anaesthesia and Recovery 2015.
- The resuscitation trolleys checked were tamper evident which meant the integrity of the emergency equipment could not be assured. We were told that new tamper evident trolleys were on order.
- Records showed that the hospital generator was not checked on a regular basis which did not give assurance that the generator would work in the event of a power failure.
- Mandatory training completion rates across the whole service were at 68% at the time of our inspection, this was worse than the hospital target of 95%.
- Training records showed that of the 35 staff listed there were 14 staff that had no basic life support or intermediate life support training. No formal administration of oxygen training was undertaken in line with guidance
- The training record for laser training was incomplete and did not give assurance that all staff had received training.
- The training database did not reflect that all staff had completed an induction programme.
- Staff had some basic training in dementia awareness and no training in learning disabilities. There were no care pathways in place for these patient groups.
- The risk register did not show a date when the risk stated was expected to be resolved.

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 to help the service improve. We also issued the provider with one requirement notice that affected Optegra Surrey Eye Hospital. 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	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with outpatients and diagnostic imaging. We rated this service as good because it was effective, caring, responsive and well-led, although it requires improvement in safety.
Outpatients and diagnostic imaging	Good 	Surgery, outpatients and diagnostic imaging were the only activities at the service. Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with outpatients and diagnostic imaging. We rated outpatients and diagnostic imaging overall as good, because it was caring, responsive and well led, although we found it to require improvement in safety. We did not rate the service for being effective.

Summary of findings

Contents

Good

Optegra Surrey Eye Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Optegra Surrey Eye Hospital

Optegra Surrey Eye Hospital is part of a specialist group of hospitals managed by the Optegra Group. The hospital opened in 2008 and serves both NHS and private patients. The hospital primarily serves the communities of the Surrey area. It also accepts patient referrals from outside this area.

The hospital is registered to provide the following regulated activities

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

The hospital has had a registered manager in post since 2008. At the time of the inspection, the current manager is the regional manager for both the Surrey Eye Hospital and another Optegra Clinic.

Our inspection team

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

Information about Optegra Surrey Eye Hospital

The hospital is open Monday to Saturday and normal working hours are Monday, Wednesday and Friday 8am to 6pm, Tuesday and Thursday 7am to 6pm and Saturday 8am to 3pm.

The hospital has two floors and during the inspection we visited the reception area, administration office, patient liaison rooms, consulting rooms, treatment room, diagnostic room, laser refractive theatre, pre-operative room and ophthalmic operating theatre.

We spoke with 17 staff including registered nurses, health care assistants, reception staff, medical staff, optometrists, operating department practitioners, and senior managers. We spoke with five patients and one relative. We also received six 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed six sets of patient records. We also requested information and reviewed policies.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected twice, and the most recent inspection took place in July 2013 which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2016 to June 2017)

- In the reporting period 1 July 2016 to 30 June 2017 there were 265 refractive intraocular lens surgery performed, 256 refractive laser eye surgery and 2,546 other surgical procedures including vitreoretinal, oculoplastic and cataract procedures. There were 1,179 injections for age-related macular degeneration and 24 treatments for glaucoma.
- There were 2,053 initial consultations and 3,375 follow up consultations.
- 10 Ophthalmologists worked at the hospital under practising privileges. Optegra Surrey employed 13 registered nurses, two optometrists and five healthcare technicians

In the reporting period between July 2016 to June 2017

Summary of this inspection

- No Never Events or serious incidents or injuries were reported
- There were 25 recorded complaints

Services provided at the hospital under service level agreement:

Clinical and or non-clinical waste removal

Pharmacy service

Interpreting services

Grounds Maintenance

Laundry

Maintenance of medical equipment

Pathology and histology

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?

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The resuscitation trolleys checked were not tamper evident, which meant the integrity of the emergency equipment could not be assured.
- The anaesthetic machine in theatre was not regularly checked: this did not give assurance that that the machine had undergone required daily safety checks in line with guidance.
- There was no capnography monitoring available for use during sedation in line with guidance. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommendations for Standards of Monitoring during Anaesthesia and Recovery 2015.
- Records showed that the hospital generator was not checked on a regular basis which did not give assurance that the generator would work in the event of a power failure.
- Healthcare Technicians (HCT's) were installing prescription eye drops without a competency assessment.
- Nurses were dispensing prescription medicines which were outside their scope of practice as they had not received additional training.
- Eye drops were administrated before the correct operative site had been marked which could increase the risk of an error occurring.
- In theatres, staff explained that medicines were prepared for dispensing before the doctor had prescribed them.This meant there was a risk if the prescribed medicines deviated from the ones normally prescribed this might not get noticed.
- Training records showed that of the 35 staff listed there were 14 staff that had no basic life support (BLS) or intermediate life support (ILS) training recorded. However there was evidence that training was booked one month prior to inspection and would not have shown on the training records.

However

- We observed a positive approach in theatre to completion of the safe surgery checklist in line with World health organisation (WHO) 'Five steps to safer surgery'. Comprehensive auditing and a culture of "No WHO, no operation' ensured all staff were engaged with the process.

Summary of this inspection

- The hospital maintained standards of cleanliness and hygiene. We observed the environment to be visibly clean and tidy with good use of personal protective equipment and good hand hygiene practices throughout the hospital.
- We saw that the hospital had developed a safe staffing policy and had a locally developed tool used to ensure staffing was appropriate across the hospital. This tool was to be shared with other optegra sites.

Are services effective?

Good

Are services effective?

We rated effective as Good because:

- There was a comprehensive annual audit plan and we saw that the results were discussed at staff meetings and areas for improvement highlighted.
- We saw that 100% of staff had an appraisal and staff told us that the appraisal process was of value.
- We observed good multi-disciplinary teamwork across the hospital
- We saw good consent processes were in place that were in line with policy.
- The hospital had access to an eye science department, whose role was to collate patient outcome data for all consultants. All Consultants had access to their data. Each quarter this outcome data was benchmarked across the business.
- Staff monitored the laser protection processes and we saw the laser protection supervisors were up to date with training.

However:

- The hospital did not engage 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).
- There were no competency checks for Healthcare Technicians to ensure that staff had adequate skills and knowledge to care for patients.
- The training database did not reflect that all staff had completed an induction programme or that all staff had received laser safety training.
- No formal administration of oxygen training was undertaken in line with guidance.

Are services caring?

Good

Are services caring?

We rated caring as Good because:

Summary of this inspection

- Patients told us they were well looked after and that the staff were caring and kind.
- We observed positive interactions by staff and that patients were cared for in a professional and compassionate way throughout the hospital
- The development of a patient liaison role focussed on giving the patient a constant point of contact throughout their stay and supported continuity of care.

Are services responsive?

Good

Are services responsive?

We rated responsive as good because:

- There was flexibility in the planning and delivery of services which met the patient needs. There was flexible management of theatre operating time and clinics to ensure patient choice and effective use of resources.
- There was no waiting list of patients for refractive eye surgery. There were no breaches of the 18 week pathway recorded for NHS patients.
- The service recognised that patients might need support with communication and were able to provide assistance in hearing and translation.
- There was clear patient information on how to make a complaint and complaints received were managed in line with policy. Learnings were shared with staff.

However

- Staff had some basic training in dementia awareness and no training in learning disabilities. There were no care pathways in place for these patient groups.

Are services well-led?

Good

Are services well-led?

We rated well-led as good because:

- There were clear lines of management responsibility and staff knew who their line managers were and spoke of their managers as being approachable and supportive.
- There were corporate values and a statement of purpose which was displayed around the hospital
- The hospital undertook an audit which measured the readiness of the hospital to receive patients in line with the safety and compliance.

Summary of this inspection

- There was a comprehensive integrated governance structure in place and meetings supporting this process were held on a regular basis and minutes shared with staff.
- There was a staff recognition scheme in place and staff were able to give examples of how this worked
- The annual colleague engagement programme showed staff engagement to be very good.
- Patient feedback was collected and results were acted on.

However

- The risk register did not show a date when the risk was expected to be resolved.
- We identified concerns in relation to; lack of policies and staff competencies around dispensing and labelling of medicines, lack of competencies for health care technicians and a lack of anaesthetic machine safety checks in theatres. This showed that the quality monitoring and assurance processes required further improvement in order to demonstrate effective management oversight.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Requires improvement

We rated safe as **requires improvement**

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

Incidents

- The hospital had a standard operational procedure (SOP) for managing and reporting incidents. This was an Optegra corporate policy. Incidents forms were printed off the local intranet system and completed by hand and given to the Clinical Services Manager. During our inspection staff were able to explain how to access the form and were able to give examples of incidents they had reported and confirmed they received feedback from incidents.
- We reviewed the standard operating procedure which was in date and was bound by the procedures relating to the 'National Framework for Reporting and Learning from Serious Incidents' and the 'Strategic Executive Information System (STEIS)' as directed by the Department of Health and NHS England and other external reporting requirements.
- Optegra Surrey hospital did not report any never events or serious incidents in the last 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The Clinical Services Manager was responsible for grading and investigating incidents. During our inspection, we reviewed three incidents and saw they had been graded correctly and investigated following a set framework. We reviewed a completed incident form and root cause analysis (RCA).
- The incident related to the loss of pressure from an air cylinder during a procedure, learning points and changes to practice were clearly identified. For example, we saw the 'theatre opening procedure checklist' had been changed to include a check of the air cylinder at the beginning of the operating list. In theatres we saw completed copies of the checklist which indicated a pressure check and air quantity had been undertaken. We saw that the investigation identified failings within surgical safety checking processes and actions were undertaken to help to prevent similar occurrences.
- We saw that incidents were a set agenda item at Medical Advisory Committee (MAC) meetings and the clinical governance meetings. These meetings included incidents from various locations this ensured shared learning. Minutes were recorded and shared amongst staff to raise awareness and learning from incidents.
- Safety huddles were undertaken daily and included important safety issues and learning from incidents was communicated at these meetings and highlighted significant concerns or potential safety issues.
- 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.

- The hospital stated they did not have any incidents that fitted the criteria for duty of candour processes, and so had not been obligated to implement duty of candour processes.
- Hospital leaders had undergone duty of candour training and were aware of the duty of candour requirements and were familiar with the legislative requirements. All staff were aware of the principles of being open and honest with patients.
- The hospital did not carry out specific morbidity and mortality review meetings; this was due to low numbers of patients who would fall into this category. However, we saw that any complications were discussed at MAC meetings and minutes of the meeting confirmed this.

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

- The hospital produced a clinical quality report quarterly, which included performance in key areas, for example; unplanned re-admissions, unplanned returns to theatre and transfers to other hospitals. This was shared within the hospital and provided an oversight of results and achievements for staff.
- The hospital was able to access clinical quality reports of other locations within Optegra. This meant they were able to monitor improvements in performance over time and benchmark against other locations. This provided an oversight of their performance and improvements or a decline in performance.

Cleanliness, infection control and hygiene

- We saw staff adhered to the corporate infection control policy which was in date and included guidelines on the management of infections affecting eyes.
- We saw that all clinical areas were visibly clean and tidy. We saw copies of daily, weekly and monthly cleaning schedules in theatres and these were fully completed.
- All members of staff we saw in clinical areas were bare below the elbows to prevent the spread of infections in accordance with national guidance.
- We saw staff wash their hands and use hand gel appropriately, for example before and after patient contact. This was in line with the world health organisation's (WHO) "Five moments for hand hygiene.
- Hand hygiene audits were carried out twice a year and results showed staff to be following best practice and these results were shared at department meetings.
- We saw personal protective equipment (PPE), readily available in the treatment rooms and in the theatre. Personal protective equipment is protective clothing such as aprons, gloves, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection.
- We saw theatre staff dressed appropriately in scrub suits and designated theatre shoes. Staff were not permitted into theatres in outdoor clothing.
- Disinfection wipes were readily available for cleaning hard surfaces and equipment between patients, we witnessed staff using these.
- The cleaning and sterilisation of equipment was undertaken at a facility off site. There was the ability to fast track items if they were required urgently.
- Waste in all clinical areas was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at work regulations. The clinical waste unit external to the building was secure.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We checked six sharp bin containers and all were clearly labelled to ensure appropriate disposal and traceability. We saw in theatres, the sharps bins were on wheels, this meant the bin could be moved to the patient and sharps could be disposed of immediately.
- The computer keyboards within the theatre were wipeable, which reduced the risk of spreading germs.
- There was access to a microbiologist for advice 24 hours a day seven days a week.
- The hospital reported one hospital acquired infection in the previous 12 months. This was managed locally with input from the local NHS trust.

- Infection control training was part of the mandatory training schedule. Data supplied by the hospital showed 66% of staff had up to date infection control training, this was worse than the hospital target of 95%.
- The hospital had a system for managing the risk of Legionnaires disease. Legionnaire's disease is a lung infection caused by Legionella bacteria. Legionella bacteria is spread when water supplies become contaminated with the bacteria which is more likely in larger, more complex water systems such as those found in hospitals.
- The facilities manager explained that the hospital manages the Legionella risk by flushing taps throughout the hospital daily and testing the water for Legionella bacteria quarterly, this was undertaken by an external contractor. We saw results of the quarterly tests which were clear.
- There was a service level agreement in place with a local independent hospital which undertook the sterilisation of reusable equipment.
- Infection Control and Prevention (ICP) was included as part of the Clinical Team meetings which were held monthly. IPC audit findings and learning was shared at Hospital Governance & Risk Meetings and Medical Advisory Committee.
- Infection control audits formed part of the audit programme in addition there was an annual external audit of the facilities and practice. We saw the January 2017 audit which showed 93% compliance.Action plans were developed after the audit to address any issues highlighted. We saw the hospitals maintained the theatre, laser suite and treatment rooms in line with the Royal College of Ophthalmologist (RCOphth) professional standards and guidance 2013.
- We saw the hospital followed the national patient safety agency (NPSA) colour coding scheme for cleaning materials. The NPSA recommend that organisations adopt this code as standard in order to improve the safety of hospital cleaning and ensure consistency and provide clarity for staff. This ensured these items were not used in multiple areas, therefore reducing the risk of cross-infection.
- The theatre had an integrated ventilation system which ensured the ventilation and temperature was maintained within safe levels. Staff monitored the temperature of the laser suite daily and we saw records that demonstrated this.
- We saw there was an infection control audit plan dated February 2017. This highlighted areas for improvement. For example we saw that the computer keyboard in theatres had been replaced with a wipeable one.

Environment and equipment

- We checked the resuscitation equipment which was accessible in the corridor outside theatre. We found the trolley was not tamper evident which meant that the integrity of emergency equipment could not be assured. We saw that a new lockable trolley was on order. We also saw a checklist for the trolley which showed evidence that staff checked the trolley daily. This provided assurances the emergency equipment was safe and fit for purpose
- All clinical areas were well maintained, free from clutter and provided a suitable environment for providing care and treatment to patients.
- There was an anaesthetic machine in theatre. However, as general anaesthetics were not given to patients this was only used to monitor patients and deliver oxygen to patients.
- We checked the anaesthetic machine and saw the logbook showed evidence of gaps in the daily checking process. For example, there were gaps on the 15 and 16 September, 8 September and 9 September 2017. This did not provide assurances that the anaesthetic machines had undergone the required daily safety check. This contravened the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. We raised this issue with the Clinical Services Manager who said they were currently discussing alternative arrangements for delivery of oxygen and patient monitoring as the anaesthetic machine was not needed. The hospital should put a regular local check relevant to the equipment being used.
- There was no capnography monitoring available within the theatre. Capnography monitors the amount of carbon dioxide (CO_2) in exhaled air, which assesses breathing during sedation or a general anaesthetic. The

Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommendations for Standards of Monitoring during Anaesthesia and Recovery 2015, recommend the use of capnography monitoring for those patients who are deeply sedated. If oral sedation is used then monitoring with a pulse oximeter is reasonable, but for intra venous sedation capnography monitoring is the standard expected.

- Theatres were fitted with an uninterrupted power supply (UPS) which meant lifesaving equipment would continue to operate in the event of a power cut. We saw the system was checked annually.
- There was a hospital generator this ensured there was a backup supply of electricity if the main electricity supply failed. However, records indicated the generator was not tested regularly each month as stated but showed it was checked twice in the current year on the 12th July and 30th September 2017. The preceding year the checks were made on the 27th December, 15th July and 4th March 2016. This did not give assurance that the generator would work in the case of a power interruption and additionally that the generator would be able to support all equipment being used within the hospital at any given time.
- The hospital maintained an asset register with details of equipment servicing. This meant there was a system, which ensured equipment was appropriately serviced and maintained. For example, we saw that the anaesthetic machine was last serviced in January 2017.
- Staff told us that it could be difficult to get equipment repaired quickly. For example a patient monitor had been awaiting repair since 25 August 2017. This might compromise staff in being able to access correct equipment.
- We checked over 20 consumable (disposable equipment) items and all were within their expiry date, which showed they were safe to use.
- We saw in theatres records on monthly equipment expiry date audits. This showed that equipment was checked and any out of date stock disposed of.
- There was a variety of service level agreements (SLA) in place which supported the running of the hospital .For example; there was a SLA for waste management and cleaning. We reviewed one of the SLA's which confirmed they were in place and they were within date.
- There were no facilities and maintenance support on site, this was highlighted on the hospital risk register. This meant that if vital equipment was faulty there was a time delay whilst support travelled to the hospital. Critical systems within the hospital were remotely monitored which allowed rapid assessment of building issues. This mitigated the risk and there were plans to review the facility and maintenance support. For example, the temperature of the theatre was remotely controlled therefore this could be adjusted remotely if required.
- Staff in theatre told us that a piece of equipment used in cataract surgery was old and often failed to work. We saw this was highlighted on the hospital risk register. The hospital quarantined faulty equipment and loan equipment had been provided. The Regional Hospital Director told us that replacements had been ordered.
- The hospital used three different types of laser machines and protective eye goggles were checked prior to every use and we saw records confirming this. Staff had undertaken training in laser protection safety and we saw completed competency documents confirming this. This was in line with optical radiation safety guidance.
- We saw laser warning signs were used to clearly identify controlled areas where lasers were in use. The refractive suite situated next to the theatre had visible signage and lights to indicate when a laser was in use.
- The laser safety management folder was located in the management office which all staff had access to. This included the laser protection advisor (LPA) contact information if required, contact details were also in the local rules which were located in the laser room.
- The LPA reviewed the file during each audit or when a change happened. The laser protection supervisor (LPS) liaised with the LPA if a change occurred during the year to ensure all information was up to date.
- The hospital had an on-site laser protection supervisor; who had received the appropriate training and

competency assessments. There were two staff members that were LPS and there was access to other LPS's at other sites, the regional facilities manager was also LPS trained.

- We saw a certificate of completion, which confirmed this. All staff told us that they had completed laser safety training however data on compliance was not available.
- Staff told us that the laser company representatives periodically provided training. A new staff member confirmed that they were not allowed to operate the laser until they had received training. We saw that appropriate records were maintained each time a laser was operated.
- The hospital LPS undertook checks of the laser equipment In accordance with local rules and policies. This was monitored by the facilities manager and clinical service manager. There were two members of staff that acted as laser supervisors. On discussion the LPS had good knowledge of their lasers, were able to locate policies and records of staff training.
- There were local rules in place which covered the specific lasers used in the hospital. These rules contained the maintenance schedules, timescales for servicing and the safety procedures associated with the laser. We saw that staff had signed the rules which confirmed they had read and understood the rules; all signatures were up to date. Rules were last reviewed in September 2017.
- An external Consultant from Public Health England (PHE) was the overall Laser Protection Advisor. PHE reviewed competencies, local rules, provided training, carried out annual audit of the LPS competence which included a review of the registers and that the laser checks had been carried out.
- All the clinical team had core knowledge training from PHE every three years; this training had been recently reviewed and was to be increased to biannual.
- There were incomplete records kept of Consultant laser training with only one Consultant appearing to have undergone generic training. This did not give assurance that all medical staff had undergone appropriate laser training.

Medicines

- The hospital had an Optegra Eye Health Care (OEHC) medicine policy, which was in date and referenced national guidance for example General Medical Council (2013), Good Practice in Prescribing and Managing Medical Devices, and Royal College of Optometrists Guidance on Independent Prescribing Nov 2015.
- The hospital had a supply level agreement for pharmaceutical products and clinical pharmacy services with an external pharmacy. This included the supply of pharmaceutical products and the provision of medicine management audits to ensure Optegra complied with all regulations and best practice guidelines.
- The external pharmacy company undertook monthly medicines management audits which included fridge monitoring, storage, records and ordering. Any areas of non-compliance were immediately flagged to the Clinical Services Manager and hospital Director via a monthly report. Head of Clinical Governance and Risk also received a group report which highlighted any areas of concern. Medicines management was a standing agenda item on all Corporate & Hospital Governance and Risk meetings. The Clinical Services Manager was the hospital lead for the safe and secure handling of medicines.
- We saw Healthcare Technicians (HCT's) installing prescribed eye drops. The hospital was unable to provide us with competency documents to demonstrate HCT's had undertaken competency training. This meant staff were not adhering to the OEHC policy which stated: "HCT's may instil prescribed drops once assessed as competent to do so and with the agreement of the Clinical Service Manager and under delegation from a registered nurse and must be able to evidence yearly review of the competency"
- The hospital did not stock any schedule 2 controlled drugs (CDs) which are medicines liable for misuse that require special management. However they did stock midazolam which is a schedule 3 CD and was correctly stored in a locked cupboard,
- During our inspection, we found that nurses were dispensing prescribed medicines from the hospital supplies for patients to take home. Whilst the Nursing and Midwifery Council gives provision for this practice as being within nurses' scope of practice, the guidelines

state that this must be in the course of the business of a hospital, and in accordance with a registered prescriber's written instructions and covered by a standard operating procedure (SOP). It also states that the patient has the legal right to expect that the dispensing will be carried out with the same reasonable skill and care that would be expected from a pharmacist.

- The OEHC medicine policy states: "Each Optegra will have a SOP for nurses dispensing medications from stock". We saw a copy of this SOP which stated nurses must undertake additional training to dispense medicines. The external pharmacy company provided annual training but it was unclear if dispensing medicines was included. Therefore nurses were acting outside of their scope of practice. We raised this issue with the Clinical Services Manager and it became clear that the need for additional training had been overlooked.
- We observed that eye drops were installed into eyes in preparation for surgery when the operation site had not been marked. This meant there was a risk that the eye drops could be installed into the wrong eye.
- In theatres, staff explained that medicines were prepared for dispensing before the doctor had prescribed them.Staff applied pre-printed prescription labels and marked on the chart that medicines had been checked and were ready for dispensing, this was completed prior to the doctor signing the prescription. When asked, staff informed this was done to save time in the morning. This meant that there was a risk if the prescribed medicines deviated from the ones normally prescribed this might not get noticed.
- We checked a sample of medicines and found these to be in date. We were advised that the external pharmacist checked expiry dates, stock reconciliations and provided stock top ups. Additional supplies were available on an ad-hoc basis if required. We also found all emergency medicines were in date for example medicines for the treatment of anaphylaxis (severe allergic reaction).
- We checked the drugs fridges and we saw records in all areas, which showed staff, had checked the fridge temperatures daily. All temperatures recorded were within the expected ranges, and there were no gaps on the checklist. This provided assurances the hospital stored refrigerated medicines within the recommended temperature range to maintain their function and safety.
- There was a completed daily checklist for monitoring the ambient temperature in areas where medicines were stored. This ensured that medicines stored at room temperature remained within the manufacturer's indicated temperature range.
- Staff were aware of the procedures to follow if temperatures became out of range and would contact the pharmacist to confirm drugs remained fit for use should this occur. Patient allergies were clearly noted on their paper notes, medicine chart and on their identity band, which alerted staff to their allergy. In theatres allergies were also documented on the wipe board. For example, we saw a patient had an allergy to iodine which was written on the white board. Iodine is also used as a disinfectant prior to surgery and an alternative solution was used for this patient.
- Mitomycin is mainly used in cancer treatment but may also be used for other purposes. Ophthalmology is not one of its licensed uses although it is used for clinical procedures including refractive eye surgery and glaucoma. This medicine poses a risk to staff and subsequent patients, if not handled safely. Cytotoxic drugs, including Mitomycin, are hazardous substances, as defined by the Control of Substances Hazardous to Health Regulations 2002 (COSHH). Under COSHH, employers must assess the risks from handling cytotoxic drugs for employees and anyone else affected by this type of work, and take suitable precautions to protect them.
- Optegra voluntarily suspended the use of Mitomycin whilst they reviewed its policies and processes in the safe handling and administration. The exception to this was if it was required for sight saving surgery. Mitomycin was used on a patient at the hospital the week prior to our inspection for sight saving surgery. Optegra had produced a draft policy for the management and administration of Mitomycin and this was adhered to.
- We reviewed the notes of the patient who underwent the surgery; they demonstrated a thorough risk assessment had been undertaken. In addition, we saw evidence in the notes that the patient was fully informed

of the risks and benefits of Mitomycin and that it was not licensed for use in eye surgery. A specific consent form appropriate for the use of this drug was used. The consent form gave all contraindications and risks related to this treatment.Alongside this a standard hospital consent form was used on the day of treatment.

- There was a cytotoxic (toxic agent) spill kit which was in date and available for use, staff knew the location of the kit.

Records

- Optegra had both electronic and paper records which were available for all appointments and surgeries, all patients had a unique identification number which was logged on both electronic and paper records. The hardcopy records had colour coded covers to identify which patients were NHS and which were private patients. This system enabled staff to ensure patients received correct referrals following procedures.
- The electronic system was integrated into the diagnostic equipment within the hospital and data was electronically uploaded.
- The transportation of private patient records was either undertaken by a consultant with the relevant indemnity. NHS notes were requested electronically, delivered and collected by a member of the NHS hospital staff in line with their policy. We saw these were stored securely in a locked cupboard in the administration office. The hospital had a service level agreement with a records management for the archiving of patient records
- We reviewed five (hardcopy) patient records and saw evidence of clear documentation, with no loose records. Staff had signed and dated all entries. This was in-line with guidance from the General Medical Council. We saw staff had fully completed all five care pathways. Records were legible, accurate and up to date.
- We saw the theatre records section of care plans were clear and safety checks documented to ensure safe surgery and treatment was undertaken.
- Patient records included information such as the patient's medical history, previous medicines, consultation notes, treatment plans and follow-up notes. In addition, information specific to the treatment needed for example, the recommended type and prescription of lens to be implanted during surgery based on various test readings. In addition, we saw the type and prescription of the lens required was documented in red pen on the consent form.
- The hospital used procedure specific pathway documents, which followed the path the patient took through a specific surgical episode such as a cataract surgery. Cataract surgery is the removal of the natural lens of the eye that has developed an opacification, which is referred to as a cataract. This meant specific risks associated with these procedures were assessed. In addition, it meant all relevant information was in one place and all related information was easy to find.

Safeguarding

- The hospital followed the OEHC safeguarding adult's policy which was in date and referenced national guidance for example, Department of Health Safeguarding Adults: The Role of Health Service Practitioners (2011). Staff confirmed they knew where to access the policy if required.
- The Clinical Services Manager was the hospital lead for children and adult safeguarding who was able to provide advice when necessary. There was a national corporate safeguarding lead that was also available to provide advice and oversight.
- There were no safeguarding concerns reported to CQC in the previous 12 months.
- Safeguarding training was included in staff mandatory training. Eighty-eight percent of staff were up to date with level 2 adult and children safeguarding training. This was worse than the hospital target of 95%. Although the hospital did not treat children, they undertook child protection training this ensured staff were able to recognise and respond to potential safeguarding issues concerning children who may visit the hospital.
- Staff demonstrated an understanding of their safeguarding responsibilities and an understanding of safeguarding procedures.

Mandatory training (if this is the main core service report all information on the ward(s) here.

- The hospital followed the Optegra training policy. Staff were required to undertake a range of general and role

specific mandatory training modules these were a mixture of face to face and online training. This was in line with the policy and the mandatory training schedule, which set out the frequency that each module needed to be repeated.

- Training modules included the mental capacity act and deprivation of liberty safeguards (DoLS), basic life support (BLS), infection prevention and control, manual handling and equality and diversity.
- All clinical registered staff were expected to undertake Intermediate Life Support training. Admin staff were to complete BLS training. No members of staff had Advanced Life Support training, but we were told that this was planned for the clinical lead but there was no date for this training to be undertaken. Looking at the training records of 35 staff there were 14 staff that had no BLS or ILS training. However there was evidence that training was booked one month prior to inspection and would not have shown on the training records.
- The training database showed that mandatory training completion was not consistent completed by all staff for example the majority of staff were out of date with health and safety training. Talking to staff they told us that they were not always sure when training was scheduled to be carried out. Staff told us that they would only do training if there was time.
- Training completion rates across the whole service were 68% at the time of this inspection. This included mandatory and role specific training.

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

- The hospital did not have a specific admission or exclusion criteria for patients. They assessed the suitability of each patient on an individual basis. Staff told us that generally patients who classed as level 2 or 3 within the American Society of Anaesthesiologists (ASA) Physical Status classification system were accepted. A triage process, outpatient consultation and pre-assessment were undertaken either over the phone or in person to assess if the hospital could safely meet the needs of the patient.
- Patients completed a preadmission questionnaire to assess if there were any health risks, which may compromise their treatment at the hospital. Staff discussed the health questionnaires with patients in a pre-admission appointment or via the telephone. If staff had any concerns they discussed them with an anaesthetist to ensure the patient was suitable to have an operation at the hospital.
- We observed theatre staff carrying out the World Health Organisation (WHO) 'Five steps to safer surgery' checklist for procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. We reviewed five completed WHO checklists and all were fully completed. This meant there was assurance that the safety checks had been undertaken correctly.
- The clinical services manager audited the WHO checklists using the documentation audit and the newly introduced Caring, Responsive, Effective, Well-Led and Safe (CREWS) audits. The manager randomly selected ten sets of notes to audit from completed by three different surgeons.
- The September 2017 WHO audit checklist showed 93% compliance. We reviewed the audit which showed areas of non-compliance were highlighted and what action had been taken For example, we saw that one consent form did not have confirmation of consent documented on the day of surgery. WHO audit findings were shared during theatre staff meetings and daily briefings so learning could be shared and improvements made. The Clinical Services Manager also undertook observational WHO audits.
- Staff met for a 'team briefing' at the start of each operating list in accordance with the World Health Organisation 'five steps to safer surgery'. The purpose of this meeting was to highlight pre-existing medical conditions and allergies patients may have. Equipment requirements were also discussed and we witnessed surgeons checking the equipment available. For example, staff carried out a check to ensure the availability of implant lenses and another check was undertaken to ensure there was a backup lens available. The briefings ensured that risks were discussed and any potential issues were highlighted.
- Theatre staff used an expression which was "No WHO, no operation". This ensured all staff were aware of the requirement to undertake the WHO safety checklist.

- Theatre staff undertook a 'debriefing' meeting at the end of the operating list this was in accordance WHO 'Five steps to safer surgery'. We saw these were documented and raised issues that were positive and negative. For example, we saw during one operating list a complication had occurred and it was documented how well the team responded to this.
- We observed a 'debrief' during our inspection, we observed that the surgeon ensured that the whole team was present and that everyone had an opportunity to contribute.
- We saw in theatre that there was an effective system in place to ensure the recording of lens implants used. This was in accordance with the Medical Devices Regulations 2002. A medical implant is a device intended to be either totally introduced into the body or to be partially introduced into the body through surgery and to remain there for at least 30 days.
- Records of implants used in surgical procedures were maintained by retaining the bar codes with unique traceable reference numbers. These were recorded in patients' medical records. Patients were given a card to keep which contained the barcodes and unique reference numbers for their own lens implants.
- Serial numbers of the implanted lens were recorded in the patient's records and on their electronic record. All equipment used during surgery was recorded in the same way. This ensured the traceability of equipment if there were any later issues with implants or equipment.
- We saw that the specific type of lens implant was documented on the wipe board in theatre before the operation started. This acted as a cross reference when checking the lens prior to insertion. The theatre team had another expression which was "no lens details on the board no lens". This meant the surgeon took responsibility for writing on the board which lens was required.
- A lens checking protocol audit was carried out monthly and the last nine months showed that actions were taken when compliance was less than 100%. The most recent result in September was 100%.
- During the surgical procedure, the patient's pulse rate and oxygen saturations were monitored and displayed on a screen for team members to observe. Patients were given oxygen if required.
- Blood glucose monitoring kit seen to be in date and checked recently with appropriate use of control substance.
- Information relating to post-operative care was given to the patient when they were discharged. This included the 24 hour on call number which was manned by a registered nurse.
- The hospital had an anaphylaxis policy with a standard operating procedure of what should be done in the event of anaphylaxis and we saw posters which detailed what action to take. The Resuscitation Council guidelines were also displayed with the algorithms to follow in the event of a cardiac arrest.
- We saw Health and Safety Control of Substances Hazardous to Health were stored in line with Health and Safety Executive guideline SR24.This ensured safe storage of substances, which could cause harm to staff and prevented unauthorised access.
- There had been two incidences of unplanned transfer of care to the NHS trust within the last 12 months.
- The NHS trust was in close proximity to the hospital, consultants had admitting rights to the NHS trust and were responsible for arranging the transfer of patients. There was not a formal arrangement in place.

Nursing and support staffing

- The hospital employed four full time (FT) nurses, two part time (PT) (nurses and seven zero hour contract nurses. The hospital employed two FT optometrists, two FT technicians three PT technicians and one zero hour technician. In addition, they employed one FT and one PT other clinical staff.
- At the time of our inspection, there were two full time nurse vacancies. In the previous 12 months to our inspection, just one nurse had left the hospital.
- The theatre lists were staffed appropriately. During our inspection we reviewed planned staffing rotas, as well

as records showing the actual number of staff on each shift. These showed staffing levels met AfPP guidelines on all shifts. Staffing levels were anticipated in advance of planned theatre lists.

- The Clinical Services Manager and Patient Services Manager were responsible for creating and overseeing weekly staff rotas to ensure safe staffing and the appropriate skill mix in accordance with the procedures scheduled and patient numbers forecasted.
- We saw that the hospital had developed a safe staffing policy and a locally developed tool that allocated time to specific tasks and according to patient needs. Managers told us the purpose of this tool was to ensure staffing was appropriate across the hospital and took into account time allocated for post-operative calls, pre assessments and checks to be made on the next day schedule. This enabled staffing to be planned at least two weeks ahead. We were told that this staffing tool was to be shared with other optegra sites.
- In theatres safe staffing was followed in practice, in accordance with The Association for Perioperative Practice (AfPP) guidelines, to ensure safe, appropriately experienced and qualified staff were available to meet the demands of the patients attending the clinic. Optegra Safe staffing policy was followed and supported by local operating procedures.
- Regular Bank staff were used to backfill planned and unplanned absence.
- Data provided by the hospital prior to our inspection recorded that bank staff had covered 1007.75nursing shifts, 473.25 operating department practitioner shifts,56 optometrist shifts and 12.5 technician shifts in the three months prior to our inspection.
- The hospital used agency staff, in the three months prior to our inspection agency staff covered 671.25 shifts.
- The only sickness recorded in the three months prior to our inspection was within the nursing staff which accounted for 1.5% sickness rate.

Medical staffing

- The hospital did not directly employ any ophthalmologists, ten ophthalmology consultants worked across surgery and outpatients under the practising privileges. Practising privileges is a term that is used in legislation when a Hospital Director in conjunction with the Medical Advisory Committee (MAC) grants permission to a medical practitioner to practice in that hospital.
- The hospital 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.
- Medical oversight was maintained by the Optegra National Medical Director from whom advice could be sought on corporate medical matters. Local medical supervision was available from the MAC chair.
- There was evidence of a robust system to grant practicing privileges in line with the company policy. Two Consultant files checked were seen to contain appropriate checks such as disclosure and barring service (DBS), General Medical Council (GMC) checks, copies of curriculum vitae and health screening. There was evidence that all Consultant files were in the process of being checked to ensure they contained all necessary checks.
- We were told that consultants were available by telephone, when the patient's own consultant was not available cover was provided by another consultant. This was agreed informally between consultants.
- Laser sessions were planned to ensure at least one laser protection supervisor (LPS) was on site whenever laser procedures took place.

Emergency awareness and training

- The hospital had a business continuity plan was which covered potential risks such as dealing with crisis event management, IT system and hardware failures, bad weather and equipment failure. There was risk management policy, which covered non-clinical risks, for example fire, and floods.
- Staff had received fire safety training as part of the mandatory training package. We saw the names of nominated fire marshals were written on posters

throughout the hospital. Fire exits and fire assembly points were clearly signposted. Evacuation procedures were in place and emergency simulation exercises were undertaken

Are surgery services effective?

Good

We rated effective as **good.**

Evidence-based care and treatment

- The hospital had an annual audit plan which included; World Health Organisation (WHO) safer surgery, lens checking protocol, hand hygiene, consent, clinical waste, environment, decontamination and documentation. We saw on staff meeting minutes that results of these audits were discussed and areas for improvement highlighted.
- We saw the hospital had a comprehensive range of policies and procedures, which were reviewed and updated regularly and were in line with current best practice. However, during our inspection we saw the hospital was not compliant with elements of their own internal and corporate policies such as medicines management in relation to nurses dispensing medicines on discharge.
- Procedures undertaken and patient pathways we reviewed included best practice guidance. For example, patient procedures and care pathways we reviewed cited and included relevant best practice guidance such as National Institute for Health and Care Excellence (NICE) guidance for the treatment of macular diseases. Macular disease usually commences after the age of 60 and can progressively destroy the macula, the central portion of the retina, impairing central vision.
- Posterior Capsular rupture (PCR) is accepted as a common complication of cataract surgery, staff in theatres had a good understanding of the set procedures that must be followed by surgeons to address this. This demonstrated that staff were aware of the most up to date guidance and recommendations provided by NICE and the Royal College of Ophthalmologists.
- Staff told us they were kept up to date with changes in practice through staff meetings, WHO briefings and appraisals. For example, they gave examples of alerts from Medicines and Healthcare products Regulatory Authority in relation to lenses.

Pain relief

- Pain relief was administered in the form of anaesthetic eye drops prior to surgery or procedures. We observed that patients were asked about pain levels during and after their procedures.
- Patients we spoke with confirmed that their pain was monitored and treated appropriately.
- Patients received advice regarding pain relief during the discharge process. They were given a 24 hour helpline number and advised to attend a local accident and emergency department if the pain was severe.

Nutrition and hydration

- The hospital followed the Royal College of Anaesthetists guidance on fasting prior to surgery for patients receiving intravenous (into a vein) sedation. The guidance suggested patients could eat food up to six hours and drink clear fluids up to two hours before surgery. Staff advised patients of fasting times during their pre-assessment. We saw that staff asked patients to confirm the time they last ate and drank before surgery. This ensured the hospital complied with the Royal College of Anaesthetists guidelines. Patients who underwent intravenous sedation were offered refreshments after their procedure.
- Patients who were not having intravenous sedation were offered refreshments prior to and after their procedure.

Patient outcomes

- Optegra had an Eye Sciences division, which amongst other activities managed the collection and reporting of clinical data. This data covered clinical complications, visual and refractive outcomes for laser, lens replacement and cataract patients. This data was captured using an electronic patient record (EPR) system. This data was reported at quarterly at meetings of the Optegra UK Board, Medical Advisory Committees and Corporate Governance Committees. The measures were benchmarked against industry standards for

Cataracts, Laser and refractive lens exchange (RLS) patients. The latest report from September 2017 was seen. This was sent to surgeons with their own personal data.

- A national audit monitored for compliance; Eye Sciences facilitated this. However, the hospital does not submit data to the National Ophthalmic Database Audit (NODA). The purpose of NODA is to collate anonymised clinical care data collected using electronic medical record (EMR) for the purposes of national audit, research and establishing meaningful measures for revalidation.
- The hospital did not engage 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.
- In the 12 months prior to our inspection there was one unplanned return to theatre following refractive eye surgery (RES).
- In the 12 months prior to our inspection 40 patients had unplanned re-treatment or treatment enhancement following RES.
- Of these 40 patients, 19 eyes had laser enhancement following refractive lens exchange (RLE) which was part of their treatment pathway and none returned to theatre within 28 days. Seven patients had secondary lenses following RLE surgery, none of these patients returned to theatre within 28 days. Fourteen patients had a redial of their lens following surgery.
- In addition, 13 reported opacification (clouding) of their lens these were being managed corporately, investigations were still ongoing and each was reported to Medicines and Healthcare products Regulatory Authority.
- A cataract is a misting up of the natural lens, which sits just behind the pupil and helps to focus light on the retina. Cataract surgery involves replacing the misty natural lens with a small, clear synthetic implant called an intraocular lens (IOL). The focusing power of the IOL can be chosen to reduce dependence on glasses after surgery (refractive lens exchange)
- Posterior capsule rupture (PCR) is a recognised complication of cataract surgery, occurring in around 1 in 50 patients (just less than 2%). Rates are higher in those with known risk factors, for example dense cataract. Data provided to us showed there had been one occurrence recorded by the hospital out of 548 procedures in the last 12 months. This was a rate of 0.18%, better than the national average.
- The hospital reported one other intra-operative complication during cataract surgery which related to a wound problem.
- Refractive lens exchange (RLE) is the default option for vision correction surgery in the over 65 age group, but laser vision correction may still be a better alternative for patients with no signs of cataract and good eye surface health. Laser vision correction does not require a lens implant, and works by altering the curvature and focusing power of the front surface of the eye.
- Data supplied to us by the hospital showed between July 2016 and June 2017 none of the 254 patients who underwent refractive lens exchange (RLE) experienced an operative complication. This was better than the industry benchmark of 95%.Data collected by the hospital from patient questionnaires showed that out of 546 patients who underwent RLE 95% of patients were satisfied with their treatment.
- Data provided by the hospital showed between July 2016 and June 2017 all of 239 patients who had primary laser vision correction surgery with eligible outcomes achieved 6/6 and 6/12 unaided vision. Data collected by the hospital from patient questionnaires showed that out of 386 patients who had laser vision correction surgery 99% of patients were satisfied with the outcome.
- The hospital audited the surgical performance of each individual surgeon and this was demonstrated to us and patient outcomes were collated to ensure they were meeting best practice standards. Outliers were investigated and action plans created as required. Each consultant was sent a personalised report.

Competent staff

- We reviewed the arrangements to determine that staff were competent to undertake their assigned roles. We reviewed four staff training records, whilst we saw there

was competency documents for bank and permanent qualified staff, health care technicians (HCT's) did not have competency documents. This meant there was not a process in place to ensure they worked within their scope of practice or competence. During the inspection we did not see any evidence that their practice was poor.

- Agency staff were booked through one single agency. The clinical services manager had confirmation of professional registration, references, competency and other appropriate checks prior to them arriving at the hospital. We saw there was an induction checklist completed for agency and bank staff.
- The hospital had not ensured that staff responsible for the management and administration of medication were suitably trained and competent. We did not see evidence within staff files of qualified nurses to confirm they had undertaken additional training to confirm competence.
- All new staff were expected to complete an induction programme, which included; health and safety, access to systems, mandatory training, human resources and policies and procedures. Staff had a six month probationary period. We spoke to a new member of staff who confirmed they had undertaken the induction programme which was thorough and gave them the information they required. However the training database did not show that all staff had all completed induction.
- We did see that there was no formal oxygen training for staff. Training to ensure staff are aware of the implications and risks associated with oxygen therapy is recommended by the National Patient Safety Agency (NPSA) RRR/006.
- The laser protection supervisors (LPSs) attended Core of Knowledge Laser Safety training every three years unless there was a change in regulation. This was monitored, reviewed and audited via an on-line training tracker. We saw the two laser protection supervisors were up to date with training.
- Consultants wishing to undertake any new procedures would be discussed at the medical advisory committee. If agreed as appropriate then they would be signed off by the medical director.
- The learning needs of permanent staff were identified through a system of appraisals and one to one meetings. Data supplied to us by the hospital confirmed all staff had an appraisal completed within the last 12 months.
- Of the three consultants who performed refractive eye surgery at the hospital Royal College of Ophthalmology Certificate in Laser Refractive Surgery and the remaining two were refractive practitioners. This meant that consultants were appropriately qualified and experienced.

Multidisciplinary working

- During our inspection, we observed good multidisciplinary teamwork between disciplines. All staff knew what their role was and how this fitted into the team. Staff told us that they worked together as a team and knew about each other's roles and responsibilities in the hospital.
- In theatres, we saw all disciplines of staff worked well together and everyone had a voice and their opinion heard. This was demonstrated at the WHO debriefing session we observed that the consultant surgeon ensured all team members were present.
- The hospital had effective external working relationships through service level agreements with external contractors to facilitate the effective running of the hospital. For example, this included the provision of pharmacy services, laundry and cleaning.
- The hospital had built up relationships with community eye organisations and personnel for example optometrists, opticians and community nurses.
- During our inspection, we were given an example of the hospital liaising with a local care agency to ensure the patient's eye drops were administered after they were discharged home.

Seven-day services

- The hospital was open Mondays, Wednesdays and Fridays from 8am until 6pm and Tuesdays and Thursday's 7am until 6pm.The hospital was open between 8am and 3pm on Saturdays. This meant patient could access services at a time likely to be convenient for them.

- The hospital provided a 24-hour helpline for advice to patients outside of normal working hours; this was covered by a qualified nurse. Consultants were available during normal working hours to review patients if staff felt it was required.

Access to information

- Optegra UK used an electronic based clinical record, the system held records of clinical information including scans which upload to the system. This was accessible from both Optegra Surrey hospital where the surgery would have taken place and also Optegra Solent hospital which is the only other location where a patient could potentially attend for follow up.
- NHS patients from the local NHS trust had their care and treatment documented in their paper record which was returned the following day after surgery. NHS patients remained the responsibility of the hospital the night of their operation, at 8am the following day the NHS hospital resumed responsibility.
- Staff confirmed they had access to details held on the electronic patient record and paper notes. This included past medical history, allergies referral letters and medicines.
- Paper records were archived to an external storage facility once the patient was discharged. There was a system which ensured the hospital could recall them if required.
- Correspondence was sent from the consultant to the patients GP and referring Optometrist as appropriate, with a copy to the patient, providing information relevant to the patient's condition and treatment (unless the patient had stated that they wished otherwise when they completed and sign their registration form).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff followed the corporate consent policy; the policy incorporated the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) legislation. The policy set out what the responsibilities of staff were when seeking and obtaining informed consent, including the type of consent (verbal or written) required for different procedures undertaken at the hospital.
- We observed one patient just prior to surgery and before going through to theatre. We saw that the consent form was checked the consultant gave a full explanation of the procedure, expected outcomes and possible complications.
- MCA and DoLS legislation training was part of the mandatory safeguarding vulnerable adults training, 88% of permanent staff and 45% of bank staff were up to date with safeguarding training. This was worse than the hospital target of 95%.
- The hospital had never had the need to seek a deprivation of liberty authorisation.
- Consultants were responsible for obtaining informed consent from patients, this was undertaken at consultation and confirmation of consent was undertaken on the day of the procedure. We reviewed six consent forms, all were fully completed were legible and did not contain any abbreviations. All consent forms contained the risks and benefits of the procedure.
- We saw that the confirmation of consent was undertaken at the 'Sign In' and 'Time Out' steps of the 'World Health Organisation five steps to safer surgery'. This ensured confirmation of consent and site of surgery was confirmed prior to the procedure commencing.
- The Royal College standards (April 2017) for refractive eye surgery state, "A minimum cooling off period of one week is recommended between the procedure recommendation and surgery". All of the six consent forms we reviewed complied with this standard.
- Patients told us that they were given sufficient information in order to make an informed decision regarding treatment and informed consent.
- Staff told us that they rarely treated patients who lacked capacity. However, the capacity of a person to consent to a procedure was assessed by consultants and staff during consultation and pre-assessment. If a patient lacked capacity staff made a decision if the needs of the patient could be met at the hospital. If the patient's needs could not be met for example, if they required a general anaesthetic they were referred to a NHS trust.

Are surgery services caring?

Good

Surgery

Good

We rated caring as **good.**

Compassionate care

- We spoke with four patients who had surgery at the hospital. All patients we spoke to felt staff were caring. One patient told us “they were very apprehensive but had been reassured throughout” and another patient told us all the staff were very kind.
- We saw staff took time talking to patients and explaining things to them and those people close to them. For example, in theatres the consultant explained everything that was going to happen at every stage of the procedure. Constant reassurance was given to a patient throughout their procedure and we saw staff held a patient’s hand to provide comfort and reassurance.
- We saw in theatres consideration was given to preserving patients’ dignity. For example, patients were seen individually in a consultation room, discussions regarding care pathways were addressed in private and where patients did not wish their GP to be informed this was respected.
- Data on patient satisfaction was collated using electronic or paper based questionnaires.
- A patient survey was sent out to patients in October 2016 capturing data from patients who used the hospital between 01 April and 30 June 2016.The survey captured data from seven Optegra hospitals ,Surrey hospital had a response rate of 17% and 86% percent of respondents would recommend or strongly recommend Surrey hospital to a friend or relative.
- We saw that patient feedback was a standard agenda item on clinical quality reports and hospital meetings.
- We received six patient feedback comment cards, five of these contained positive feedback. Comments included “All staff were very caring and pleasant” and “Amazing care would recommend to everyone”.
- There was a chaperone service available and we saw posters advertising patients of this service.

Understanding and involvement of patients and those close to them

- We saw staff took time talking to patients and explaining things to them and those people close to them.
- Discharge arrangements were considered pre-operatively and discussed with patients and relatives to ensure appropriate post-operative caring arrangements were in place. For example, assistance in administering eye drops. This also reflected patient centred care and that patient’s individual needs were taken into consideration.
- Consultants took time to ensure patients had realistic expectations of their procedure before consent was obtained. Patients were given ‘cooling off’ periods to ensure that they had fully understood and considered all the information available to them.
- We observed staff taking time to explain follow up care and instructions to patients during the discharge process. This included explaining to family and relatives how to correctly administer the different eye drops as the instructions on the packaging was small and patients with impaired vision may not be able to read them. Information regarding bathing, showering and cleaning the eye was also given.

Emotional support

- All staff had undertaken service excellence training which aimed to enhance insight into communication styles and the language used to assist the patient journey in a positive way.
- The hospital provided clear information on pricing for different surgeries. Following surgery refractive eye patients were given written information regarding follow up care. The hospital promoted the patients right to choice and were open and transparent regrading expectations and fees.
- We saw in theatre one particular patient was extremely anxious, this was communicated to the theatre team prior to the patient arriving in theatre .Staff discussed how they would ensure the patient was reassured throughout the procedure and allocated one member of staff to hold their hand. This member of staff stayed with

them throughout their procedure and escorted them to the recovery area .The patient comment on how caring the staff were and how they would have no hesitation in having the procedure on the other eye.

- Staff understood the emotional impact that sight problems might have on patients. Staff told us that improving a patient's sight was what they were passionate about.

Are surgery services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- The hospital opened in June 2008 and sought advice and input from private and insured patients and local commissioning groups in the designing, furnishing and equipping of the hospital. The hospital was designed to mirror the pathway of patients from consultation, with room for all relevant equipment for diagnostics through to disease management or treatment including facilities for day surgery for adults.
- The hospital was easily accessible and well serviced by public transport and there was ample free parking right outside the door.
- We saw that the facilities were spacious and fit for purpose. Staff and patients were positive about the environment.
- The hospital engaged with all key stakeholders for example local NHS commissioners in to understand what services were required. The hospital had a close relationship with the local acute NHS trust for which it provided a service. There were weekly meetings between the hospital and the NHS trust to discuss service provision and availability.
- The hospital provided pre-planned services only, this meant they had control regarding of the amount of patients that they were able to accommodate. The hospital proactively forward planned surgical and clinic sessions of private, insured and NHS patients. They had flexibility to increase or decrease the number of surgical sessions required dependant on the patient need and at busy times.
- If a surgeon had planned time off then the theatre list would be offered to other consultants or additional NHS sessions would be offered. This optimised theatre utilisation and periods of inactivity, staffing was planned dependant on activity.

Access and flow

- Patients accessed hospital services via three main routes, those who had private medical insurance, via NHS commissioning or patients choosing to self-pay.
- The hospital currently had no patients on their waiting list for refractive eye surgery.
- The hospital had cancelled two refractive eye surgery procedures patients in the 12 months prior to the inspection for non-clinical reasons.
- All NHS referrals were booked according to patient suitability at the hospital via the patient administration system. Self-pay and insured patients were either referred by their GP, Optometrist or they self-refer. The details were logged on to the patient administration system and confirmation of the appointment was sent out. All new appointments were backed up with a welcome call to reassure the patient of next appointment, the letter also included a map of the clinic with directions and parking information and a patient registration form and a medical questionnaire.
- The hospital had a contract with the local commissioning group to provide 10 operating lists a month, the hospital provided the theatre, theatre staff and equipment and the local NHS trust provided the surgeon. The patient remained the responsibility of the hospital overnight and then transferred back to the care of the NHS trust at 8am the next day. Additional ad-hoc sessions were arranged in addition to the contract subject to NHS waiting lists and availability.
- As part of the quality data required by NHS contracts the hospital was required to meet the 18 week Referral to treatment (RTT) pathway. There were no breaches of the 18 week pathway recorded.

- Private patients could arrange a free no obligation consultation with ophthalmologists to discuss potential treatment. The hospital also had 'open evenings' which patients could attend, consultants and staff were on hand to discuss various treatments on offer.
- All necessary diagnostic tests were completed on the first appointment along with an assessment with the consultant. If deemed suitable patients were offered surgery and added to the waiting list. Staff aimed for patient appointments to take between one to two hours and the clinical service manager monitored arrival and assessments times.
- Telephone triage clinic appointments were in place to review patient's self-assessment information prior to surgery. Face to face pre assessments were also undertaken if deemed appropriate based on the telephone triage appointment.
- Each patient had a patient liaison person who facilitated the pathway of the patient from referral to discharge and acted as the liaison between the consultant and patient should there be any queries or concerns that need to be addressed.
- On the day of surgery patients checked into the main reception area, they were then called through by a member of staff and pre-operative checks were undertaken and eye drops administered, from there they were taken to the pre theatre waiting room upstairs via the lift, they waited there until called into theatre. During their procedure they were on a reclining operating table which they are transferred on to recovery. If the patient had sedation the patient would stay in recovery until transferred to the ward. Patients who had procedures under local anaesthetic without sedation would go straight back from theatre to the day ward for discharge.
- Patients were kept informed of the list order and how many patients were in front of them.
- Follow up appointments were arranged as outpatients at clinic for reviews during the discharge process.
- A copy of the discharge letter was given to patients on discharge from the hospital. Copies were also sent to the patient's GP unless the patient states otherwise and or optometrist/optician. The letter recorded the procedure the patient had and details of any post-surgery medicines they had been given to take home with them.

Meeting people's individual needs

- All surgical patients had a pre-operative assessment undertaken by a nurse to insure individual medical needs could be met.
- Medical questionnaires were provided ahead of appointments for patients to indicate their personal and individual needs.
- A hearing loop system was in place to help patients who had hearing aids.
- There was access to an interpreter and a choice of languages for standard literature. Patient information leaflets were also available in large font for patients with impaired vision.
- A wheelchair was available for patients who may not be mobile but could access the clinic for their appointment. The hospital had a lift to enable access to all parts of the hospital.
- There were no specific care pathways in place for patients with living dementia or learning disabilities. Staff told us how they rarely treated patients living with dementia or learning disability. Staff were able to give example of how they would adopt to accommodate their specific needs for example; ensuring patients were first on the theatre list and allowing relatives and carers to accompany them into theatre during their procedure.
- Staff did not have any specific training in caring for patients with a learning disability. Staff told us they had 'dementia awareness training' and this was completed two years previously, they did not know if there would be an update to that training, however, dementia training was included in the safeguarding vulnerable adult training.
- There were no adaptations in the environment for people living with dementia. For example, appropriate signage. However, there was staff available to guide patients where they needed to go throughout the hospital if required.

Learning from complaints and concerns

- The hospital had a system for handling complaints and concerns and followed the organisation's corporate complaints policy. The policy provided a structured process for staff to follow when dealing with complaints.

We reviewed the policy which was in date, had recently been reviewed and was in line with recognised guidance and contractual obligations for independent hospitals in England.

- The hospital received 25 written complaints in the 12 months prior to our inspection. Of these, 10 were managed under the formal complaints procedure, two of which were upheld. We reviewed three complaints during our inspection, we saw that they were handled in line with their policy. Staff told us one of the most frequent complaints from patients was waiting times between having their diagnostics undertaken and their appointment with the consultant. The clinical service manager told us that they were monitoring waiting times and looking at different options to reduce waiting times. One of these was to streamline the diagnostic tests into a shorter time.
- Staff told us that they tried to resolve complaints informally at the time to stop them escalating to formal complaints. Staff aimed to resolve issue there and then. If the complainant felt the issue remained unresolved then they were informed of the formal complaint process. The patient was given details of the complaints process and what to do should they wish to take their complaint further.
- All complaints including informal complaints were captured, tracked and reported on an electronic database, we reviewed this during our inspection. Stage one- a letter confirming receipt of the complaint was sent out within two working days and the complaint was then investigated. A full response was usually made within 20 working days of receipt of the complaint. If this was going to be longer a further letter was sent to the complainant to explain why this was the case. An extension of time was agreed with the complainant. The outcome of the investigation and detailed response was sent to the complainant no later than five working days following the conclusion being reached.
- At stage two there was access to an internal appeal if the patient was not happy with the initial response this was escalated to the Managing Director, this stage was 20 days for a response. If the patient was still not happy they could refer to The Independent Healthcare Sector Complaints Adjudication Service (ISCAS) which was an independent external review company who offered impartial advice and support for the patient.
- The patient and clinical services managers were responsible for responding to complaints before they became formal and the hospital director (registered manager) was responsible for responding to formal complaints.
- Managers told us complaints, compliments and learning from incidents were shared at hospital and team meetings, medical advisory committee and integrated governance meetings and actions recorded. We saw meeting minutes which confirmed this. Informal complaints were shared at the daily meeting with staff .
- The complaints procedure was included within the patient guide which we saw was available in the reception area. We saw posters around the hospital which gave details on how to raise concerns, compliments or complaints. Patient feedback questionnaires were available in all patient areas.

Are surgery services well-led?

Good

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

Leadership / culture of service

- The service was led by the hospital director who was in addition the hospital's registered manager. At the time of the inspection the hospital director also managed another Optegra site and split his time between the two locations. The hospital director reported to the Optegra UK chief executive.
- The hospital had a Patient Services Manager and Clinical Services Manager who were responsible for managing front-line staff and reported directly to the hospital director.
- There were clear lines of management responsibility and accountability within service. Staff had a good awareness of who their line managers were which included their individual roles and responsibilities. Staff told us they all worked well together as a team. We saw teamwork was particularly good within theatres with each staff member having a voice and an equal place within the team.

- Staff told us that local leadership was good and managers were approachable, supportive and took an interest in their welfare. Managers we spoke with appeared knowledgeable about their patient's needs, as well as their staff needs. Staff were committed to making improvements for patients and felt they were starting to be able to influence change.
- There was an equality, inclusion and human rights policy. The policy described that every manager employed by Optegra was responsible for promoting equality inclusion and human rights in their sphere of management and for preventing undue discrimination in practice. The policy included clear aims and objectives.

Vision and strategy for this core service

- Optegra had shared values which described how they behaved towards patients and one another, to ensure this impacted positively on the quality of life of the patient and had driven their business success.
- The hospital had a statement of purpose which shared its vision and values with patients. Their objective was to be the "most trusted" eye care provider, putting patients at centre of what they did.
- Their strategic aim was to provide appropriate service and care for each patient in the best environment and at the right time. Care would be provided by the colleague who was competent and best placed to deliver that care.
- We saw the hospital statement of purpose was displayed around the hospital. Some staff, but not all, could tell us what the strategic aim was.

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

- The hospital director was the location lead for governance and quality monitoring. He was supported by the clinical services manager who provided the quarterly performance and quality reports.
- Optegra had introduced a local balanced score card that measured key performance indicators (KPI's) across a variety of areas which included colleague satisfaction, impact on patients, processes andbusiness financials. This incorporated 11 KPI's, and was benchmarked against best practice, and was measured and reported monthly.
- Monthly audits were undertaken for example, World health Organisation 'five steps to safer surgery' and we saw there was learning shared from audits and action taken.
- Weekly operational review calls and monthly operations meetings were held with hospital directors across Optegra's seven hospitals to share insight and benchmark across other hospitals and clinics.
- The hospital undertook a caring, responsive, effective, well-led and safe (CREWS) audit which measured the readiness of the hospital to receive patients against the key lines of enquiries (KLOES), which consisted of a short 15 step check to ensure safety and compliance.
- Surgical outcomes were collated by the Eye Sciences division and shared with the hospital director. They were discussed and reviewed at the hospital medical advisory committee (MAC), with individual consultants, and at the corporate governance committee on a quarterly basis. Eye sciences did not bench mark outside Optegra, but looked at and considered international data and reviewed published papers reflecting outcomes for cataract procedures.
- The hospital held Clinical Service Managers (CSM) meetings quarterly, which were attended by UK clinical lead and head of clinical governance and risk, together with all clinical service managers (CSM's) from UK Optegra hospitals and held ten times a year. Key areas discussed were; medicine management, infection, control, safe guarding, clinical incidents and health and safety. Incidents were shared between Optegra hospitals for learning. The CSM meetings ensured commonality across the hospitals, shared pathways, documentation and encourages staff recognition of their relationship with Optegra. We reviewed the minutes of these meetings and saw evidence of shared learning.
- An integrated governance steering group was held quarterly and attended by Optegra UK senior management team, including hospital directors, function heads, Eye sciences, medical director and Optegra UK Managing Director. At the meetings, the reports from the hospital level governance groups were

reviewed to ensure consistency, monitor trends and adherence to policy and outcomes data, complaints and serious incidents were also reviewed. We saw evidence of this in the meeting minutes we reviewed. We saw terms of reference for this group.

- A Medical Advisory Committee (MAC) was held four times a year which was attended by the chair, an optometrist, clinical nurse, consultant and a spread of sub-specialities for glaucoma, refractive eye surgery, cataract, cornea and retinal. We reviewed the last three meeting minutes which showed these were well attended. We saw issues discussed at the MAC meetings included, adverse incidents, complaints, infections, safety issues and learning was identified for discussion from adverse incidents and events.
- The risk register contained eight active risks within the hospital. Risks were categorised into three categories; financial, quality or operational and accurately reflected all the risks within the hospital. The register contained a description of the risk, impact of risk, risk score an action plan to mitigate the risk and nominated person responsible for the action plan. However, the register did not show a date when the risk was expected to be resolved, or if it was ongoing.
- We identified concerns in relation to lack of policies and staff competencies around dispensing and labelling of medicines, lack of competencies for health care technicians and a lack of anaesthetic machine safety checks in theatres. This showed that the quality monitoring and assurance processes required further improvement in order to demonstrate effective management oversight.

Public and staff engagement

- Optegra had a staff recognition scheme whereby staff could nominate individuals and teams. A member of staff told us that they had received champagne and flowers in recognition of completing her academic studies.
- Staff were offered health insurance cover and childcare vouchers as part of their employment package.
- An annual colleague engagement survey was conducted with the results shared openly with colleagues and action plans developed. Results of a survey in January 2017 showed staff engagement to be very good.
- Staff told us that the hospital was a good place to work and that there was a good team culture with staff supporting each other.
- There was evidence that the hospital acted on feedback from staff. The changing rooms were cramped and untidy, storage drawers were purchased to store clean theatre clothes outside the changing rooms which created more space inside the changing room. In addition, staff felt the theatre scrubs were tatty and there were limited sizes available, therefore new scrubs in a range of sizes were purchased.
- The hospital had a comprehensive website with information regarding the range of treatments available for patients including information regarding costs and finance.
- The hospital held open evenings periodically when the public were invited to view the facilities and ask any questions regarding the process and procedures.
- The Optegra website advertised a free no obligation quote, to test the patient's suitability for refractive eye surgery. However, this was only available to private patients.
- There was a patient liaison meeting held quarterly and we saw meeting minutes which confirmed this. These meetings provided an opportunity for patient's feedback to be discussed.
- We saw cards and leaflets with information for patients on how to leave feedback. In addition, their website had the facility for patients to leave feedback. Patient views were sought by a survey on an electronic tablet.
- We saw that patients were asked to feedback on their treatment and care. In July 2017, 60 patients were asked for feedback and 37 replied. The survey included ten questions and patients answered all questions positively. In response to the question, are you willing to recommend Optegra to friends and family, 33 responded certainly, three responded as likely and one as may do.
- There was evidence that the hospital acted on patient feedback. For example, patient feedback indicated that areas of the hospital were cold during autumn and winter therefore additional wall mounted and portable heaters were purchased and installed.

Good

Surgery

Innovation, improvement and sustainability

- The service was interested in expansion and treating more patients. Saturday working allowed the service to give patients more choice and availability. The manager told us there was an established contract with the local Clinical Commissioning Group and additional volume from the local trust hospital for patients requiring treatment for cataracts. There were also improvements in private and self-pay volumes.
- With recruitment of nursing staff being a challenge, the development of site specific safe staffing levels for theatre and outpatients developed in line with Royal College of Ophthalmologist Guidance and AFPP guidelines showed dynamic and active management of allocation of staff to meet service demand.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement

Incidents

Please see the surgery section for full details

- The hospital had a standard operational procedure (SOP) for managing and reporting incidents, this was an Optegra corporate policy. Incidents forms were printed off the local intranet system and completed by hand and given to the Clinical Services Manager. During our inspection staffs were able to explain how they had access the form and were able to give examples of incidents they had reported and confirmed they received feedback from incidents.
- Staff working in the department described an open culture of reporting incidents and felt able to suggest or challenge patient treatments with consultants. They told us they would be able to approach and discuss with senior management if they had concerns about a consultant's practice or treatment.
- Medical staff told us that there was an open culture of reporting incidents and knew these were discussed at the Medical Advisory Committee and they would receive a copy of the minutes of that meeting which meant lessons learnt were shared with them.
- Information provided to us by the service showed that there were no reported never events in relation to the outpatient department in the last year. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff told us there were daily meetings at the start of the day to discuss clinics, treatments, work allocation and any staffing concerns. This also provided an opportunity to discuss any incidents and lessons learnt.
- There had been no incidents in relation to OPD that required a duty of candour response.

Cleanliness, infection control and hygiene

Please see the surgery section for full details

- There had been one incident of a healthcare acquired infection in the last twelve months when a patient developed a post intravitreal inflammation having had a course of twelve injections. Seven other patients on the list treated by the same consultant at the same day and time were reviewed and had no symptoms. There were no other cases reported for the year.
- The outpatient department was visibly clean and tidy. Staff monitored the cleanliness of the department and cleaning staff completed daily general cleaning checklists to ensure all areas of the department were cleaned on a daily basis, records looked at were seen to be complete.
- Spillage and cleaning products were available to staff. Staff spoken to were able to explain how they would deal with a spillage.

- We saw "I am clean stickers" on equipment to provide staff with assurances that, equipment was cleaned and ready to use.
- We checked three diagnostic rooms on the ground floor and saw there were non-touch taps. Hand gel was present and the World health Organisation (WHO) 'five moments of hand hygiene' information was displayed by hand wash sinks.
- Staff in the clinical area were bare below the elbow to prevent the spread of infections in line with national guidance. Personal protective equipment such as gloves and goggles were available in the department and we observed the staff using personal protective equipment appropriately.
- Checks for legionella had been carried out during the past year and flushing of all taps and outlets was done weekly. Records for the last six weeks in the outpatient department were seen to be complete.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We checked three sharp bin containers in the outpatient department and all were clearly labelled to ensure appropriate disposal and traceability.
- There were systems for the correct segregation and disposal of waste. Cleaning staff removed clinical waste daily and placed it in bulk storage bins within a secure compound until collected. This area external to the hospital was seen to be kept clean and tidy.

Environment and equipment

Please see the surgery section for full details

- The outpatient department comprised of a reception area, administration offices, patient liaison rooms for private and confidential conversations regarding booking and billing. Three consulting rooms, toilet facilities, one treatment room and six diagnostic rooms
- We found the outpatient department to be well maintained, the corridors were free from clutter, there was good signage and the environment was suitable for caring for and treating patients.
- Resuscitation equipment was available for use in an emergency. We saw that equipment on the trolley was checked every day to make sure that all equipment was within expiry date and tested that it functioned safely. The trolley was not lockable but staff informed us that lockable trolleys were on order and we saw evidence of this.
- There was a copy of the laser safety policy available in the outpatient department which staff had access to. Staff spoken to were aware of the local rules. There was one YAG laser kept within the department.
- The external maintenance team managed a planned preventative maintenance schedule which had appropriate checking systems. The equipment we checked had an up to date safety test and service checks. Five year fixed wire test results were seen which showed regular electrical checks were completed.
- Service checks were seen to be entered onto a data base enabling a check to be made to see if all equipment has been serviced. Random checks of the air handling unit, fire alarm system, allegretto laser and an infinity phaco machine showed that regular servicing was carried out and records kept. A medical asset register was seen to be in place and alongside that a list of planned preventative maintenance of equipment was maintained and showed equipment to be on regular check list that was current and complete.
- Staff told us that they had appropriate resources to be able to carry out their role fully. They did require additional equipment for diagnostic room two and the manager had agreed funding for this.
- Medical staff in outpatients told us that that they have access to all the equipment they need and they would be able to approach senior managers if they required anything additional
- External to the building grounds were clean and tidy and CCTV was seen to be at the four corners of the building and was monitored at reception.
- When the hospital is closed, security was provided by a third party security team that managed all surrounding buildings in the location where the hospital was based. All contracted staff had a main key and alarm fob and swipe card. The key allows entry into the building, the fob deactivates the intruder alarm and the swipe card

gives allows access. A list of all staff with access to the building was maintained to ensure that all security measures were monitored and that staff returned items when leaving.

Medicines

Please see the surgery section for full details

- We saw medicines were stored securely in locked cupboards to prevent inappropriate access.Lockable fridges were in place and records showed the temperature checks were carried out on a daily basis.
- Ambient room temperatures were also checked where drugs were stored and there was evidence that remedial action was taken if the temperature was outside the recommended range.
- The medical gas storage compound was located at the rear of hospital building. This was seen to be secured with CCTV coverage. Air and oxygen cylinders were securely stored in this area which seen to be clean and tidy.
- We were told that medical staff would prescribe all medicines required for patients. There were no clinical independent prescribers.
- There was a Control of Substances Hazardous for Health (COSHH) folder for some substances and a policy was being developed for the management of COSHH, which we saw.

Records

Please see the surgery section for full details

- Optegra had both electronic and paper records which were available for all appointments and surgeries. All patients had a unique identification number which was logged on both electronic and paper records. The hardcopy records had colour coded covers to identify which patients were NHS and which were private patients.This system enabled staff to identify where the patient should be referred following treatment.
- In the outpatient department including reception and the administration office we saw that patient information was managed in a confidential way. No patient records were left unattended and all computer screens containing patient information were locked when the operator was away from their work station.
- Electronic patient records were only accessed by authorised staff, computer systems were password protected. Paper records were manged securely.

Safeguarding

Please see the surgery section for full details

- The hospital did not offer appointments to children in outpatient clinics. All patients were over the age of 18.
- On the ground floor and within the outpatient department there was information informing staff of the leads for safeguarding.The registered manager was the lead for safeguarding children and the clinical services manager the lead for adults. Alongside this was the escalation process to be followed in the case of a safeguarding concern and phone numbers for the local safeguarding board were included.
- Staff spoken to were aware of their responsibilities in reporting a safeguarding concern and gave an example of an incident in the department when a relative was seen to be overbearing in the care of the patient. This was reported through to the manager who ensured the patient had a chaperone in place for their appointment.
- All administration and clinical staff spoken to told us they had level two training. Information submitted by the hospital showed 88% compliance for adult safeguarding and child protection training. The clinical services manager had completed level three training.

Mandatory training

Please see the surgery section for full details

Nursing staffing

Please see the surgery section for full details

- Most clinical staff worked across surgery and the outpatients department. The hospital used bank staff andagency staff when necessary.
- The clinical services, patient services and diagnostic services managers worked together to manage the staffing across the outpatient department. A staffing sheet showed that staff with the right skills were allocated to specific work areas. With the development of the staffing tool staff were allocated time for pre-operative assessment and post-operative telephone calls.

Good

Outpatients and diagnostic imaging

Medical staffing

Please see the surgery section for full details

- Consultants working at the hospital covered their own outpatient clinics on a sessional basis.
- The service employed two full time optometrists who worked within the outpatient department undertaking pre-operative checks and referrals for surgery and post-operative clinics.

Emergency awareness and training

Please see the surgery section for full details

- The ground floor of the building was seen to have fire curtains installed which compartmentalised the area. There was an up to date fire policy in place and staff spoken to were clear on actions to be taken if the fire alarm sounded during working hours. Three members of staff were designated as fire wardens and at least one fire warden was on duty at all times.
- On the ground floor of the building we saw there were three areas where there were carbon dioxide and foam fire extinguishers. There was a break glass point and fire evacuation instructions were clearly on display positioned by the fire exits. All fire exits were kept clear of equipment which ensured that in the case of any emergency these exits could be safely utilised.
- Checks of fire alarms seen and these are carried out fortnightly. Fire extinguisher checks seen to be carried out on a regular basis and these records were seen.
- Fire wardens completed an additional module of training annually and this was seen to be complete. Evacuation training was carried out annually.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not currently rate the effectiveness of outpatient's services.

Evidence-based care and treatment

Please see the surgery section for full details

- The hospital did not participate in any national clinical audits relevant to the outpatient department.
- Staff in the department told us how they kept up to date with any changes in practice and had access to policy documents to support their care delivery.

Pain relief

Please see the surgery section for full details

- We spoke to two patients who were attending the hospital for appointments post procedure and both said they had found their procedures to be carried out with little or no discomfort and no pain.
- Pain relief was given pre surgery consultations by the use ofanaesthetic eye drops.

Nutrition and hydration

Please see the surgery section for full details

- In the reception area of the hospital there were refreshments available for patients and their relatives.

Patient outcomes

Please see the surgery section for full details

Competent staff

Please see the surgery section for full details

- Staff told us that on starting at the hospital they completed an induction programme and there was a system of 'buddying' staff. Having a more experienced member of staff working alongside them to support them in learning their role before being left to work independently.
- Two staff members we spoke to told us they had access to training but did not always have time to attend which was a frustration. Another member of staff described Optegra as being open to continuing practice development and that they felt able to request further training.
- Staff we spoke to told us their appraisals had been completed and they had targets and objectives set for the year ahead. Two staff had also had a six month review of progress during the appraisal year. One staff

who returned from a long period of leave had an appraisal completed on their return which helped them settle back into their role and to know what was expected.

Multidisciplinary working

Please see the surgery section for full details

- During the inspection we observed all staff in the outpatient department working well together. Staff we spoke to talked about a friendly team that worked together with respect for each staff member's skills. Nursing and clinical staff told us that they felt able to approach the medical team with any patient concerns.
- There were quarterly hospital meetings with attendance by staff across all disciplines at which information was shared about the hospital performance, pathways and employee engagement. An action log was attached for all staff which enabled everyone to see who was responsible for each action.
- Discharge letters were sent to GPs following treatment to inform them of treatments undertaken and any follow up treatment.

Access to information

Please see the surgery section for full details

- Clinic information and patient notes were accessible to relevant staff.
- We looked at how information needed for staff to deliver safe treatment was made available. Staff confirmed they had access to details held on the electronic patient record and paper notes. We saw that patient files were made available for each appointment and for staff to monitor patients after their surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Please see the surgery section for full details

- We saw an example of a consultant following hospital policy and gaining consent from a patient for a course of injections. This consent was recorded in the patient records.
- One patient we spoke to told us that the procedure they had undergone had been explained to them and consent had been obtained.
- Staff we spoke to were aware of and had access to the Optegra Mental capacity Act Policy (incorporating Deprivation of Liberty Safeguarding DoLS). Staff told us that in the case of a patient not having capacity, this would be recorded in the patient's notes.On the day of inspection we were not able to see any examples of this.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as **good**

Compassionate care

Please see the surgery section for full details

- In the reception area we saw that patients and relatives were greeted on arrival, advised of the waiting time before being seen and were directed to refreshments if that was appropriate.
- We observed staff to be polite and professional in their interaction with patients. We saw that patients were escorted from reception to the consultation or treatment room and staff engaged in conversation with the patient answering questions and explaining where they were going and what was to happen
- Two patients we spoke to in the department told us that staff had been kind and reassuring and one commented that they had previously had treatment at the hospital and staffhad been helpful and caring.
- We saw that staff had access to a patient privacy and dignity policy and this set out the expectations of each staff member to patients and visitors. This included how to introduce themselves and to enquire how the individual's preferred method of address.
- We observed that all staff wore identification badges and introduced themselves to patients. We saw that staff knocked on treatment and consulting room's doors before entering which ensured that care was taken to ensure privacy and dignity.

Good

Outpatients and diagnostic imaging

- The outpatient department had appropriate rooms for private consultation and there was signage on the door which indicated if the room was free or engaged. This minimised the risk of interruption during a consultation and supported the patient's privacy and dignity.
- We saw that there were notices in the department informing the patients how to ask for a chaperone if they wished to have that support for their appointment.

Understanding and involvement of patients and those close to them

Please see the surgery section for full details

- Staff told us that they encouraged patients to bring relatives to appointments with them. Patients told us they felt involved in their care and their appointments were made to suit their availability and that adequate time was given.

Emotional support

Please see the surgery section for full details

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

Please see the surgery section for full details

- Senior managers told us that the service had an ongoing commitment to working with the local Clinical Commissioning Group (CCG) to provide a service for NHS patients. In addition the local trust commissioned work for patients on an as required basis.
- The service used an appointment system to plan and manage clinic sessions. With the growth of business, clinics and treatments now take place on Saturdays as well as week days and evenings. Staff worked flexibly to accommodate any additional clinics.
- The waiting area in reception was comfortable and patients and relatives had access to hot and cold refreshments and toilet facilities.

Access and flow

Please see the surgery section for full details

- Patients were able to arrange outpatient appointments via a range of means. Self-paying and insured patients were able to self-refer without a GP appointment.
- Staff told us that they would always try to accommodate patient requests for particular appointment times.
- Staff told us that development of the optometrist led screening service allowed easier access for patients interested in undergoing a vision correction procedure.
- All patients would report into the reception area and there appeared to be adequate seating for patients and relatives on the day of inspection. Waiting times for patients would vary according to how busy the hospital was. Waiting times were not monitored.

Meeting people's individual needs

Please see the surgery section for full details

- We observed that the hospital provided disabled parking spaces directly outside the main entrance. A toilet for those patients with a disability was located close to the main entrance.
- The outpatient department was on the ground floor and easily accessible for patients. There was a lift to access the first floor where theatres was located.
- There was clear signage in the main reception area that there was a hearing loop in place to help patients who had hearing aids.
- Toilets were available for visitors and one of these was clearly marked as suitable for disabled patients and on checking was clean.
- The hospital had developed the role of the patient liaison person who worked with individual consultants and was a key contact for that consultant's patients supporting continuity of care. The role would take into account any patient needs and concerns and support an individualised approach to their care

Learning from complaints and concerns

Please see the surgery section for full details

Good

Outpatients and diagnostic imaging

- Outpatient staff had access to the complaints procedure and staff spoken to were able to tell us what actions they would take if a patient made a verbal complaint.
- There was information in the outpatient department about how to feedback any compliments or complaints.

Are outpatients and diagnostic imaging services well-led?

Good

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

Leadership and culture of service

Please see the surgery section for full details

- Outpatients was led by the Clinical Services Manager and patient services manager who reported to the Regional Hospital Director. Staff told us that the management team was visible in the department and were approachable and supportive.
- Staff talked about good teamwork and a culture where everyone worked together to provide the best care for the patient. One staff member described their return from an extended period of leave and how they were positively supported to settle back into the work environment.
- Staff told us they were most proud of the patient centred approach to care and how they planned ahead and made the best use of capacity.
- Medical staff described the clinical team at the hospital as efficient and friendly.
- Staff told us they were aware of the "whistleblowing" policy but told us they would feel able to raise any concerns with their line managers first.

Vision and strategy for this core service

Please see the surgery section for full details

Governance, risk management and quality measurement

Please see the surgery section for full details

Public and staff engagement

Please see the surgery section for full details

Innovation, improvement and sustainability

Please see the surgery section for full details

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure they have robust systems in place for the administration and dispensing of medicines to ensure the provision of safe care and treatment to patients.
- The provider must ensure that all staff have attended mandatory training.
- The provider must ensure all safety checks of equipment and the generator are carried out on a regular basis

Action the provider SHOULD take to improve

- Resuscitation trolleys should be tamper evident to ensure the integrity of the contents.
- The provider should put in place appropriate capnography monitoring of sedated patients in line with recommendations.
- All staff including healthcare technicians should have the right competencies to meet the needs of the patients.
- The provider should ensure the training database accurately reflect staff mandatory training compliance and induction records.
- The hospital should work with the Private Healthcare Information Network (PHIN) so that data submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA).
- The provider should ensure the risk register is fully complete.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (g) the proper and safe management of medicines. Medicines were prepared for use before they were prescribed which could increase the risk of a medicines error occurring. The provider could not provide assurance that staff were competent to carry out certain medicines related tasks (dispensing and labelling). Regulation 12 (2) (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. The provider did not ensure that all staff had attended mandatory training. Regulation 12 (2) (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way. The provider did not ensure all safety checks of equipment and the generator were carried out on regular basis.