Optical Express Limited

Bridgewater Wellness Clinic

Inspection report

120 Princess Road
Manchester
M15 5AT
Tel: 01617245600
www.opticalexpress.com

Date of inspection visit: 26 October 2021
Date of publication: 06/01/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

The service had enough staff to care for patients and keep them safe. Staff had mandatory training in key skills to care for patients. The service had infection prevention control policies in place and controlled the risk of infection well. Staff investigated incidents and learned lessons from them.

Staff provided good care and treatment to patients. The corporation and location manager monitored the effectiveness of the service and made sure all staff were competent and outcomes were positive.

Staff treated patients with compassion and kindness, respected their privacy and dignity and took into account their individual needs. The service identified the needs of patients and they learned from complaints.

Staff were clear about their roles and responsibilities and felt respected, supported and valued. The service engaged well with patients to plan and manage services and all staff were committed to improving the services continually. The registered manager ran the service well and used reliable information systems and supported staff with their development. Staff said that they felt that management were approachable and that they would raise concern if they had any.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Refractive eye surgery	Good 	The service had enough staff to care for patients and keep them safe. Staff had mandatory training in key skills to care for patients. The service had infection prevention control policies in place and controlled the risk of infection well. Staff investigated incidents and learned lessons from them. Staff provided good care and treatment to patients. The corporation and location manager monitored the effectiveness of the service and made sure all staff were competent and outcomes were positive. Staff treated patients with compassion and kindness, respected their privacy and dignity and took into account their individual needs. The service identified the needs of patients and they learned from complaints. Staff were clear about their roles and responsibilities and felt respected, supported and valued. The service engaged well with patients to plan and manage services and all staff were committed to improving the services continually. The registered manager ran the service well and used reliable information systems and supported staff with their development. Staff said that they felt that management were approachable and that they would raise concern if they had any.

Summary of findings

Contents

Summary of this inspection

Background to Bridgewater Wellness Clinic

Bridgewater Wellness Clinic is operated by Optical Express Limited. The clinic provides refractive eye surgery procedures for self- referring, privately funded adults over 18 years of age. The clinic offers laser vision correction treatments and intra ocular lens replacement on the ground floor of the premises. Ground floor facilities include a discharge room, a laser treatment room (theatre), an anaesthetic room and ophthalmic theatre. The facilities on the first floor include a patient waiting area and examination rooms.

The clinic provides intra ocular lens replacement surgery under topical anaesthetic and laser vision correction procedures using Class 4 and Class 3b lasers. The treatments are carried out by ophthalmologists employed by the service. The service is only intermittently operational. Refractive eye surgery only takes place on a limited number of days each month. Treatment days are supported by a regional surgery team that also carries out treatment at the provider's other locations across the North West and Yorkshire regions. CQC register Bridgewater Wellness Clinic to carry out the following legally regulated services treatment of disease, disorder or injury, surgical procedures and diagnostic and screening procedures.

The clinic has been registered with the Care Quality Commission (CQC) since July 2015. It has had a registered manager in post since registering with the CQC in 2015.

How we carried out this inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We inspected the service using our comprehensive inspection methodology. Two inspectors carried out the inspection on 26 October 2021, led by the head of hospital inspection.

On the day of inspection, we spoke to five members of staff, the registered manager and the nominated person.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

- The service should ensure it updates its policy and review processes on the destruction of drugs such as Midazolam
- The service should consider how it stocks medicines in its fridges and improve the storage process.
- The service should ensure there is a process in place for calibration of blood pressure machines.
- The service should ensure that it is monitoring fridge temperature that are used to store medicines and that these are within the correct ranges.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Refractive eye surgery

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

Are Refractive eye surgery safe?

Good

Mandatory training

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

Staff received mandatory training in such areas such as consent, duty of care, conflict resolution, health safety and welfare, fire safety, moving and handling, equality and diversity, information governance and infection control. Staff had protected time to complete training, whole days were blocked out to allow staff time for meetings and training. The service had mandatory training of 100%.

Staff received and kept up to date with their mandatory training. Mandatory training was delivered either face to face or through e-learning modules. There were two systems for mandatory training, an online system and the staff members personal files. Mandatory training was provided on induction and was audited every six months.

The surgery manager and registered manager monitored training compliance on an individual basis and staff were notified when training was due to expire. Staff had received training in adult basic life support and key personnel such as medical staff, operating department practitioners and scrub nurses had completed training in immediate life support.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The clinic did not provide services to patients under the age of 18 years and children were not allowed in the surgical areas.

Staff received mandatory training in the safeguarding of vulnerable adults and children. Records showed that all staff had completed safeguarding training.

There had been no safeguarding incidents reported by the service between October 2020 and October 2021.

Staff had level 1 and level 2 safeguarding training and were aware of how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

There was a safeguarding adults and children policy in place and information on how to report safeguarding concerns within the service and to external bodies such as the local authority and the Care Quality Commission. The registered manager was the safeguarding lead for the clinic and was level 2 trained, staff could also speak to an external level 4 trained individual who worked centrally for optical express.

Cleanliness

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

The clinic areas, theatre area and recovery room were visibly clean and tidy. Cleaning schedules and daily checklists were in place and fully completed. Each staff member had a clearly defined role and responsibility for cleaning the environment and cleaning and decontaminating equipment. Management allocated cleaning tasks each day during staff safety huddles and checked cleaning schedules had been completed each day.

Equipment such as optical assessment units, trolleys and tables were visibly clean, and staff were witnessed to regularly clean and decontaminate these areas with disinfectant wipes between patients. This included all medical devices that may have been used.

Both staff and patients were given masks on entering the building. Personal protective equipment such as gloves and aprons were readily available and gowning procedures were adhered to in the theatre area. There was a hand wash sink seen in each clinical area. There was hand gel readily available throughout the clinic. Staff we saw were compliant with bare below the elbow guidance. All surgical staff wore disposable surgical scrubs while in the surgical suite.

Infection prevention control audits such as hand hygiene were carried out quarterly or more often if there were known issues. Infection control and hand hygiene training was included in mandatory training requirements. Infection prevention control audits carried out in June 2021 and August 2021 achieved compliance of 97% achieving the providers minimum target of 85% compliance.

Staff used appropriate aseptic non-touch techniques (ANTT) to minimise the occurrence of infection during surgery. Sterilisation of surgical equipment was carried out externally by an external provider, this process was audited monthly and showed no issues with regard decontamination.

Clinical waste bins were foot operated and were visibly clean, clinical waste was removed by an external company. Waste awaiting collection was stored securely. The scrub sink in the theatre had soap and alcohol gel dispensers. Deep cleans of the department where carried out on an ad hoc basis by an external provider. The location had a full time cleaner who has a cleaning schedule for three common areas.

Air particle testing was carried out in the theatres twice yearly, last completed in June 2021 which showed no issues. In December 2020 the theatre air exchange was validated by an external company.

The department water was supplied by a cold-water tank, in the event that the department had not been operational for 48 hours then staff would run the water for three minutes at the start of the day. There was a legionella risk assessment in place and water samples were analysed for legionella, E. coli and pseudomonas, which was last checked in August 2021 by an external laboratory.

Environment and equipment

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

The clinic waiting areas, assessment rooms, theatre area and recovery room were all maintained, spacious and free of clutter. The waiting areas and assessment rooms were located on the second floor of the premises. These premises were accessible for patients with wheelchairs and there was a lift in place. There were both separate male and female toilets on both floors.

The surgical treatment area was located on the ground floor and consisted of a surgeon's room where patients were reviewed, an anaesthetic room, surgical theatre and recovery suite were located on the ground floor and could only be accessed by key card.

Staff changing rooms were located on the ground floor and surgical staff changed into clean disposable scrubs.

All areas were tidy and free from clutter and provided a safe environment for patients, visitors and staff. All clinical areas had easy clean surfaces in case of spillages, and it was visibly clean and free of dirt. All storage areas were organised and tidy.

There were controlled areas' signs in place, and these were in working order. Hazard warning lights boxes were also in place and in working order. These signs were outside theatre areas to make it clear when it was safe to enter.

There was an emergency trolley with equipment which was checked and signed for each day. This consisted of a defibrillator, emergency suction equipment, oxygen cannister, airway apparatus and emergency drugs. The emergency trolley was visibly clean and all equipment was in date.

All doors were unobstructed and fire escapes were clear, there was fire extinguishers situated across the department and these were maintained and had been checked. Fire extinguishers had been last checked by an external provider in July 2021. The department carried out its own fire safety risk assessment in house

In the surgical theatre, air temperature and humidity were monitored by staff on a daily basis. There was a power failure risk assessment in place and in the occurrence of a power failure during a surgical procedure the department had both instant powers system and uninterrupted backup generators.

Equipment was maintained by an internal team however some equipment in the department was maintained by the manufacturer. There was a maintenance folder for all equipment, this was audited monthly and all maintenance was up to date. This folder also showed a planned maintenance schedule for items that would be due servicing in the future.

Laser servicing was carried out by the manufacturer, certificates showed that laser equipment had been serviced and maintained, with services in July 2021, February 2021 and December 2020.

We saw evidence of Portable appliance testing was being completed across the service. We reviewed five items which included a fridge and suction machine which has been tested in the last year and were deemed safe for use.

Blood pressure machines were not serviced or calibrated. Managers told us that abnormal readings were double checked manually and if issues persisted these machines were replaced. However, there was a risk that incorrect readings would not be identified if they were in normal parameters.

There were air conditioning units in place which were last checked in September 2021.

The department did not have piped oxygen and instead used oxygen canisters, cylinders were stored securely in the discharge area, if oxygen cannisters needed to be replaced this was carried out by an external company who replaced all canisters every year.

There was an approved list of staff trained to use the laser equipment and staff were trained by the manufacturer. There was one competency for all laser training, and this was completed every three years.

There was an external laser protection advisor who visited every three years and completed an onsite risk assessment, reissued and revalidated local rules (summary of instructions intended to restrict exposure in radiation areas). The local rules had been signed by all staff to confirm they read and understood them.

In the surgical theatre, staff used a theatre operation register, which contained the date and details of each procedure and staff present such as the surgeon. Labels and serial numbers were noted of the equipment and medicines used for traceability in the occurrence of faulty stock. Batch numbers and expiry dates were also noted.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Patients received an initial assessment to determine their suitability for treatment at the clinic. This included a health questionnaire to review the patients' medical history and eye tests were performed.

On the day of surgery, patients had an initial assessment carried out by a surgery associate where repeat eye tests were carried out to confirm that there were no changes since the initial consultations. The patient was then seen by an optometrist who carried out routine monitoring observations such as blood pressure to ensure any condition could be promptly identified.

Patients were asked if they had any allergies, such as latex and this was recorded on the patient records.

Finally, patients were assessed by the ophthalmologist surgeon on the day of surgery to ensure there has been no changes to the medical condition and the decision to commence with treatment was made.

At each point of patient contact, staff were witnessed to verbally check patient name, date of birth, allergies and correct procedure with the patient prior to surgery.

Good

Refractive eye surgery

The surgical team worked to collectively minimise the risk of surgical errors. The team carried the World Health Organisation Surgical Safety Checklist before each patient, they followed the core standards such as operate on correct patient at the correct site, consistently use methods known to reduce risk of surgical infection and secure and accurately identify all surgical specimens.

We witnessed patients who stayed in the discharge room after their treatment, patients were offered a drink, and were given discharge and aftercare information which was discussed with patients. Once patients confirmed they were well and happy to leave they could leave the department. Each patient had to be collected by a chaperone. The details of this nominated person were taken and they were contacted when the patient was ready.

The service had a Laser Protection advisor whose role it was to undertake risk assessments, provide appropriate safety training and draft and issue local rules for safe practice.

Information was clearly discussed and instructions for the administration of eye drops, pain relief, and returning to exercise. Any questions were answered on an individual patient basis.

In the event that a patient's health deteriorated staff told us they would contact 999 and the patient would be transferred to the nearest acute hospital. There were signs of sepsis posters around the department which clearly highlighted to staff what to do if they thought a patient might have sepsis. The service had a policy for resuscitation and the management of deteriorating patients in place.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

The department had a medicines management policy which was last updated in August 2021, it gave guidance to staff on the handling storage and security, ordering and disposal of medicines.

Medicines such as eye drops given to patients during their treatment and after their discharge were prescribed by the ophthalmologist. Staff who administered these eye drops had completed competency assessment. These eye drops included antibiotic eye drops, anaesthetic eye drops, anti-inflammation eye drops and lubricant eye drops.

An information leaflet was given to each patient who was discharged which explained how many times a day eye drops needed to be administered. We observed two patients being discharged and the member of staff at the discharge lounge thoroughly explained the process for eye drops administration.

Drugs which had expired were disposed of by staff on the premises using a controlled drug disposal kit or pharmaceutical waste bin.

No controlled drugs were stored or administered at the department; the main medicines used were topical eye drops. The service had a stock of Midazolam which was not routinely used. It was stored securely, and the service had a record of stock, usage and destruction. Staff were destroying unused Midazolam using a controlled drug destruction kit. The destruction process had not been fully completed and staff were not able to tell us how long the destruction kit had been in use.

We looked at four patients' medicines administration records, patients had allergy status documented, patients were given their medicines as prescribed and records were fully completed.

There was a monthly stock take process in place to allow for ordering, storage and disposal of medicines which have ran out or expired. We looked at a sample of medicines and found them to be within manufacturers expiry date and stored securely.

The premises had two fridges for the storage of medicines. These were not stocked in line with best practice cold chain guidance, this was highlighted to staff during the inspection. Staff monitored the fridge temperature daily. When we reviewed these records, we saw the temperature had been out of range on several occasions. Although managers told us they had sought advice from a pharmacist we did not see any record of this.

Following the inspection, the manager informed us that the service had purchased a larger fridge for the storage of medicines. They had destroyed the destruction kit that was seen on inspection and had updated the policy for the destruction of controlled drugs.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The clinic used both paper and electronic systems for patient records, hard copies of patient notes were stored appropriately and locked away.

Hard copy notes contained information such as pre- operative assessment, general health questionnaire, patient information packs, consent forms, details of surgery.

All electronic notes were held centrally by optical express which allowed the organisation to share information if a patient moved area and needed treatment.

Theatre records were hard copies on the day of surgery, these were scanned and added to the patients electronic file.

Each patient completed a health questionnaire at their initial consultation which identified co-morbidities and asked about job role and hobbies that may impact on post-surgery care.

We looked at four records which contained all the relevant information. Each document had been dated and signed, the documents were all legible.

The paper and electronic record systems had templates for staff to use to ensure that all the required information was obtained and recorded. Electronic records had mandatory fields which meant that staff had to complete them.

Nursing and medical staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix

Staff rotas were prepared centrally by the corporate provider. Staff members were part of a larger regional team and had a base location where their personal file was held. Managers told us that this system allowed for staffing gaps to be easily resolved.

The clinic had a policy which outlined the correct staffing and skill mix during the working day for each procedure. The provider had a scheduling team whose job it was to schedule clinics and plan staffing rotas. The manager reviewed skill mix in advance and each morning at the team brief to ensure the surgical team had the correct staffing level and skill mix. It was the surgery managers role to raise concerns about staffing to the corporate provider.

On the day of inspection, the surgical team consisted of an ophthalmologist, two scrub nurses, an operating department practitioner and two surgery associates this was in line with the services policy for staffing. There was also a nurse in the discharge suite.

Patients also saw a surgery associate and optometrist prior to their surgery for a pre assessment.

Managers told us that the clinic rarely used agency staff, and if used this would be in the form of an ophthalmic scrub nurse who would not work alone in theatre but as the second scrub nurse. Agency staff were not used in the other areas of the clinic.

The registered manager told us the clinic had a low staff turnover. There were a number of new staff however this was due to service expansion and not staff replacement.

Clinical staff had professional registrations with the relevant body and managers kept a record of these and performed compliance checks. We saw that the surgeons met the registration, training and practice requirements of the Royal College of Ophthalmologists standards for refractive surgery and that managers monitored this.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

There was an incident and near miss policy which had been updated in August 2021 and outlined the process for identifying and reporting incidents and near misses. Incidents could be logged through an incident reporting form which could be sent electronically or printed off and filled out.

There was a surgical services memo which was shared nationally through the provider, this allowed for lessons to be shared and these lessons were discussed at team briefs each morning.

The clinic undertook scenario-based training sessions for patients who have collapsed from anaphylaxis, cardiac arrest and asthma attack. These were recorded and lessons were shared with staff at team briefs and team meetings.

There had been 20 incidents in the last 12 months. There had been no near misses recorded in the last 12 months and one never event reported in 2019. This was fully investigated and attributed to human error.

The clinic had a risk management policy which outlined to staff their responsibilities to patient welfare and safety.

Good

Refractive eye surgery

The clinic had a duty of candour policy which recognised the responsibility for openness and transparency when things went wrong. When we spoke to staff, they were aware of both their responsibilities towards duty of candour and incident reporting.

Are Refractive eye surgery effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Care and treatment were delivered to patients in line with local and national guidelines, including Royal College of Ophthalmology standards for refractive laser surgery and implantation of intraocular lens, and National Institute for Health and Care Excellence (NICE) guidelines.

Staff were aware of the signs of sepsis and understood the importance of patients being treated promptly and effectively. There was sepsis information and signs in the department to aid staff in recognising sepsis and what to do if a patient became unwell.

Staff could access policies and clinical suitability guidelines through the organisation's intranet. The clinical suitability criteria was reviewed annually by an international medical advisory board. Any guidance or recommendations were reviewed internally by the provider medical advisory board.

All policies and procedure we reviewed were in date. If changes were made with regards evidence-based practice and treatment guidelines, the corporation sent a directive from central office, staff were required to confirm they had read and understood the guidance.

All patients had their needs assessed and their care was planned, all treatments offered were based on clinical needs of the patients and delivered in line with evidence-based practice. We saw in the records of one patient, the patient had chosen the treatment option which was not the primary recommendation of the surgeon. Staff had discussed this at length with the patient and explained the risk and benefits of surgery options with the patients to ensure they understood before they made an informed decision.

Nutrition and hydration

The service provided refractive eye surgery procedures and hydration and nutrition assessments were not routinely carried out due to the nature of the services provided.

Due to the nature of refractive eye surgery there was not a prerequisite for nutrition and hydration requirements for patients. Due to the procedure being carried over a short period of time, patients were not routinely offered food and drink. However, we witnessed staff asking patients if they had eaten a substantial meal the morning of the operation and staff also offered hot and cold beverages, both pre and post-surgery.

Good

Refractive eye surgery

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Patients were administered with anaesthetic eye drops before their procedure; staff explained to patients that if they experienced pain at any point during their procedure to tell a member of staff.

The anaesthetic eye drops were administered to ensure patients did not experience any pain or discomfort. This allowed patients to be awake during their surgery and be fully responsive. We witnessed during the surgery both the ophthalmologist and scrub nurses were in constant interaction with the patient and asked if they felt pain or discomfort at any point.

Patients were prescribed anaesthetic eye drops post-surgery that they were to apply at home, directions for use were explained by the discharge member of staff. Staff also supplied information leaflets on side effects patients may feel in the days after surgery.

Patients told us that their pain was managed well and the information on after care was well explained and easy to understand.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Patient outcomes were monitored centrally by the provider, the data collected enabled the service to monitor the demographics of the patients in terms of age, gender and treatment type. This data included data on the number of treatments, improvements in vision and number of complications.

Patient experience questionnaires were given to the patient at each stage of the process to measure satisfaction with the process and treatment.

Optical express employed a statistician who collated the data such as complications, outcomes and patient survey outcomes from each surgeon's outcome, this was collated and used as part of the surgeon's appraisal process.

The provider held annual events for surgeons to discuss overall outcomes with the medical director and then held one to one meetings to discuss outcomes further. However due to the pandemic these had not taken place in both 2020 and 2021. We saw that the information had still been collated and shared with the surgeons.

The corporate provider had carried out analysis which compared results of its intraocular lens procedure and compared this to NHS benchmarked data. This analysis was achieved through post-operative patient questionnaires. This analysis showed that patients had a higher likelihood excellent visual outcomes and lower chance of suffering either an intraoperative or post-operative complication.

Competent staff

Good

Refractive eye surgery

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

The manager seen training and development as a fundamental in ensuring patients received the best possible clinical outcome and high-quality care. All staff were required to have a period of induction and training, which consisted of role-based training and competency assessments.

All staff employed as associate nurses and technicians attended core of knowledge (laser safety training) with the provider Laser Protection Advisor and attendance was required every three years. We viewed staff records which showed the completion of this competency.

We viewed five staff personal records. All five staff had received an appraisal in the last 12 months and had completed all of the required mandatory training. Employment checks had been completed in line with schedule two of the Health and Social Care Act.

The provider held a morning brief at the start of every surgical list and staff were designated roles that they were competent to perform. Staff told us they never felt they had been asked to complete a duty outside their role.

Staff received refresher training and a review of competency every three years. Surgeons had their competencies reviewed as part of their annual appraisal and review of outcomes.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

During our inspection we saw good multidisciplinary working between the team at the clinic. We observed the surgical team working well in the theatre, communication was clear, and staff knew their roles within the theatre. Each member of staff was calm and professional and they treated their colleagues with respect.

Each morning a team brief was completed which outlined staff members roles and responsibilities. The team brief was also used as an opportunity for sharing information about the days patients and if there was any specific needs or change to their care.

The morning brief was also an opportunity to share incidents that may have happened at other locations so that learning could be gained to minimise the risk of another occurrence.

Seven-day services

The clinic did not provide seven-day services.

The clinic did not operate over seven days. The clinic opened between Monday and Saturday, however patients were provided with an emergency helpline number to contact if they were concerned outside of clinic opening hours.

Health promotion

Good

Refractive eye surgery

Staff gave patients practical support and advice to lead healthier lives.

Due to the nature of the treatments given there was limited information on health promotion.

We witnessed staff offering verbal advice to patients about lifestyle choices and hobbies following discharge that may affect their recovery.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

The provider had a consent policy in place dated August 2020, which provided staff with guidelines on obtaining patient consent. Consent training was covered in staff mandatory training and compliance was 100 percent.

Patients were given written information to take away and consider before signing the consent. The patient was then contacted by a clinician to discuss any questions they may have before providing consent.

On the day of surgery, the patient was seen both by an optometrist and ophthalmologist. They discussed what the patient would experience during their treatment and allowed patients time to ask any questions or fears that they had. The ophthalmologist thoroughly explained the risk of treatments to the patient and asked if they were still happy to have treatment.

On review of four patient records, we found that informed consent was clearly recorded, and that risks and benefits of treatment had been explained to the patients.

Patients were allowed a minimum cooling off period of seven days before undergoing surgery. This cooling off period was in line with guidance from the Royal College of Ophthalmologists.

It was the responsibility of the surgeon gaining consent to assess capacity. If there were any concerns regarding the patient's capacity to consent, the surgeon must document there had been an assessment with how the decision on whether or not to proceed to treatment had been made.

Are Refractive eye surgery caring?

Good

Compassionate care

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

We witnessed that staff were compassionate and respectful to patients who used the service, patients were spoken to in a positive and informative manner. Patients were spoken to in a private setting during their treatment and their dignity was always maintained.

Good

Refractive eye surgery

We observed during one surgery, the ophthalmologist spoke to the patient throughout the procedure and asked if the patient was experiencing any discomfort, the patient commented that the constant interaction was helpful and put their mind at ease.

We spoke to three patients throughout the day of the inspection, each patient commented that all staff were friendly and caring and always asked how they were feeling. When asked about their experience they all said the service had exceeded they expectation and they would happily recommend them.

At each staff member's interaction with the patient, we witnessed staff introduce themselves and ask how the patient was feeling and at the end of their interaction ask if they had any questions.

The provider had a privacy, dignity and human rights policy in place, which outlined the importance of treating patients with respect. It also said that patients should have both their dignity and privacy maintained at all times and they should always be treated with courtesy. We observed staff treated patients with privacy and dignity all times in line with this policy.

Emotional support

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

We observed one procedure in theatre where all staff were supportive throughout the procedure. The surgeon and scrub nurses made a conscious effort to reassure patients. Theatre staff and the patient had conversations about hobbies and future holidays during the procedure which put the patient at ease and took their mind off the operation.

During the lens replacement surgery, we witnessed the surgeon continuously talk to the patient and explain what he was doing and what he needed the patient to do, assurances were continually given throughout the procedure and the patient was asked how they were feeling and asked if they wanted a break at any point.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

There was evidence in patients notes that during pre-operative assessments patients' individual needs had been taken into account. Patients were given transparent and accurate information about costs of care.

We observed one patient's full treatment pathway from consent to discharge. At each stage staff informed patients of what they were doing and checked that patients understood the procedure.

During the inspection we saw that, throughout the patient journey, staff explained the process including risks and benefits. Patients were able to ask questions and make informed choices.

Patients were given eye drops prior to, during and post discharge. A full explanation was given as to why these were given and how to administer them. Staff confirmed with patients that they understood the information and gave information leaflets with emergency contact details if they had any issues.

Good

Refractive eye surgery

Are Refractive eye surgery responsive?

Good

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Patients always had an initial consultation, which allowed staff to plan for the patient in advance, to minimise delays. Appointments were managed centrally and follow up appointments were managed by the clinic staff; every effort was made to ensure the patient was given an appointment that suited them.

The clinic undertook both refractive eye surgery and intra ocular lens replacements for private fee-paying patients over the age of eighteen. The clinic was usually open between Monday to Friday but this was based on the number of patients who required treatment.

As patients paid in advance of their treatment then 'did not attend' occurrences were rare. However managers did tell us if a patient did not attend their appointment then contact would be made by staff to ask patients if they were coming and if not the reason for this.

If there was no availability for appointments, then the scheduling team would amend availability and add clinics so that there was no wait times.

Patient whose first language was not English were offered an interpreter. Family members of friends were not allowed to interpret for patients as to reduce the risk of coercion and ensure medical information was translated correctly.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The clinic was spacious with good access and enough space for wheelchair users. There was also a lift for accessibility which was in working order.

The clinic had policies in place for equality and diversity, and human rights and all staff had completed this training. Staff had also completed training in conflict resolution.

Patients were offered hot drinks and there was a cold-water dispenser in the main waiting area.

There was access to translation services if patients needed it, friends and family members were not used. We witnessed a translator accompany a patient during our inspection.

Patients were given a range of information leaflets on aftercare and emergency contact numbers if needed.

Good

Refractive eye surgery

At initial consultation patients were assessed individually. For patients living with dementia or learning difficulties staff would make the decision whether they could accommodate these patients. For patients living with a physical disability and were unable to lie flat enough to receive treatment then the patient would be referred to their GP for an alternative treatment pathway.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Patients at the clinic were self-referring, they found out about optical express services through a number of ways, including the provider's website, from an optometrist or by asking in person at one of the provider's locations. Once patients made contact, an initial consultation was organised where verbal and written information of the procedures offered was given.

Patients were offered surgery date within days of them being deemed suitable for treatment and could have both eyes treated on the same day.

The patients we spoke with said they did not wait long on the day of treatment. They said delays were minor and staff always informed them if they were running late. Of the patients we spoke to none had ever had an appointment time changed or cancelled.

There was a sufficient amount of eye scanners in the clinic, so patients did not wait long for their pre-operative assessments. The clinic has a surgical theatre and a laser theatre and a large discharge bay. Patients were not called to surgery until the previous patient had been taken to the discharge suite.

Patients stayed in the discharge suite as long as they wanted until they felt well enough to stand up and move around. While in the discharge suite a nurse explained the administration of eye drops that the patient had been prescribed to apply post discharge. The discharge nurse also discussed with the patient who would be taking them home to ensure they were not leaving by themselves as their vision was affected in the immediate hours post-surgery.

We followed one patient in surgery, whose total treatment time was around 50 minutes. There was a short break after the first eye to allow for scrub nurses to swap and set up the surgical instruments needed for the next eye. At no point did staff seem rushed and there was sufficient time between patients to allow for preparation of the theatre for the next patient.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

All the staff we spoke with were aware of the complaints process and knew the steps to take if a patient wanted to make a complaint. If a complaint was made in person on the day of surgery, then this was escalated to managers who would discuss it with the patient and try and resolve it.

Good

Refractive eye surgery

Complaints were managed in house locally where possible and escalated centrally when needed. The clinical services were also involved in this process.

We asked four patients if they knew how to make a complaint, who all confirmed they had been given information on how to make a complaint and were encouraged by staff to speak up if they had any concerns.

The clinic received 10 complaints between July 2020 and July 2021, and there was no trend noticed in the complaints.

On inspection we witnessed both the optometrist and ophthalmologist discuss outcomes and expectations that the patients had and confirmed there was no guarantee to perfect vision after surgery and there was always risks involved with the treatment.

The clinic used the Optical Consumer complaints Service (OCCS) to provide impartial reviews of complaints if patients were not satisfied by the response given by the provider.

Are Refractive eye surgery well-led?

Good

Leadership

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

The provider's corporate structure consisted of a chief executive officer (CEO), optometry directors, operations directors, managers and optometrists and the clinical services team which consisted of the surgical services manager, location surgery manager and location surgery team.

The surgery manager was managed by the surgical services manager. The surgery manager's role was the day to day running of the clinic. The service's managers had the right skills and abilities to run the service.

The ophthalmologist was managed by the medical director who reported to the chief executive.

Staff told us they felt management were very approachable and if they had any concerns, they would be happy to raise them. Staff told us they felt the team worked well and they were supported by management.

Vision and Strategy

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

Staff told us they believed the CEO was very driven with a five-year view in place, that they were very innovative and was keen to keep developing practice and research.

Good

Refractive eye surgery

The visions, values and strategy of the provider were displayed on staff computer screens, staff had an understanding of these and were aware of the organisation's plans to expand clinic across the country and invest in treatment advancements.

Staff informed us that optical express was part of the international medical advisory board which was an independent body made up of renowned eye experts who review data and clinical protocols.

The provider had a monthly staff newsletter which linked to their vision and strategy.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

We spoke to five members of staff at the premises, all were highly motivated and were positive and happy in their job. They told us that the team worked well and that everyone got on. They said that there was an open culture and that they were supported by their colleagues and managers.

There was a whistleblowing and raising concerns policy in place, staff were aware of the importance of whistleblowing and knew how to raise concerns if needed.

Governance

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

The provider had policies in place to support the governance processes. These policies included information governance, consent, safeguarding and medicines management.

The surgery manager reviewed and updated policies accordingly and policies were dated and updated every three years. The surgical services manager was in the process of uploading these policies to the intranet to ensure staff had easy access to the most up to date copy of policies.

The provider had a corporate clinical governance committee who looked at national guidance, with updates shared at the provider's national quarterly meetings.

There was a surgical team meeting in the clinic every two months where governance, incidents and learning and changes to practice was discussed. Staff attended a team meeting every two months. We saw the minutes for the last two meetings, which were clear and highlighted future objectives and plans

We saw evidence of meeting minutes. Agenda items included incidents, duty of candour, patient feedback, complaints and directives both surgical and clinical. In the staff meeting there was an opportunity for staff to raise concerns. After the meeting staff practiced emergency scenarios for medical conditions such as cardiac arrest, anaphylaxis and asthma, staff were evaluated on their approach to the scenario and feedback was given.

Good

Refractive eye surgery

Each day the provider had a morning team brief at the start of each surgery day, this allowed staff to talk about the days patient list and highlight any individual needs and risks. This morning brief was also an opportunity to tell staff about updated policies and also talk about incidents and complaints both locally and nationally and share learning from these. These morning briefs were recorded using a standard template.

The staff we interviewed all felt they had been well trained and felt skilled and experienced to give high quality patient care. Staff felt that policies and procedure were correct and up to date and believed they were easy to understand and follow.

Staff were kept up to date with new policies though the online optical express academy. The clinical governance team in the clinic held a meeting every two months. we reviewed meeting minutes, items covered service objectives and challenges, mandatory training and competencies, incidents and duty of candour, complaints and patient feedback, audits and quality feedback and staff concerns

We reviewed the ophthalmologist's personal file and saw they had the correct registration; indemnity insurance and their clinical outcomes had been reviewed. This was used to guide their future appraisal.

We reviewed four other clinical staff's personal files, all had the correct pre-employment checks such as health declaration, reference, qualification certificates and disclosure and barring service check.

Management of risk, issues and performance

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

The provider had a risk management policy which was dated August 2020 and outlined staff members responsibility to be aware of the potential of risk of harm and their role in mitigating this.

There were risk assessments in place for patient safety such as fire and health and safety.

We saw routine audits in place for monitoring key processes within the premises such as medicines management, infection prevention and control, hand hygiene and World Health Organisation surgical safety checklist. The finding of these audits was discussed at the morning briefs and monthly staff meetings.

The provider had a risk register where risk assessments and risk assessments results were collated. Risks were graded and appropriate mitigations put in place. The risk register was used to monitor and ensure risk was being managed appropriately. Key risks were highlighted in the meeting minutes.

Surgeon's outcomes were audited on clinical outcomes and these were benchmarked against the national average, which allowed the service to highlight any issues with performance and manage accordingly.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats.

Good

Refractive eye surgery

Staff completed training in data protection and information governance as part of their mandatory training, compliance was 100%. The provider used both paper and electronic forms of a patient notes, surgical notes were on paper form but were scanned into the patients electronic file following surgery.

Patients notes were detailed and included information from initial consultation, admission, surgery and discharge, which allowed staff easy access to information about the patient's journey.

Hard copies of patient notes were filed and stored in a locked office. Staff needed password access to the computers at the premises when accessing notes and it was not possible for a member of staff to amend medical notes if they did not have the right to.

The provider's electronic system had an audit trail so that it was documented when a staff member updated and recorded details of the patient, the corporation had a plan in place to move towards theatre notes becoming electronic in the future. Records could not be edited at a later date without requesting access to records from a central provider team who monitored this.

Staff told us there was a process in place where they would be informed of any issues towards patient safety that had been picked up nationwide this could be issues with medicines or medical equipment.

Engagement

Leaders and staff actively and openly engaged with patients, staff, to plan and manage services.

Staff told us they felt well supported in their roles, and they felt they could approach managers with concerns. Staff could give suggestions at the monthly team meetings and morning brief about ways to improve patient experience and staff working. An example given was for staff to be trained in how to discuss the procedures with a patient, which in turn would save time for the clinician and reduce waiting times at the clinic.

The provider had an annual anonymous staff survey which was completed on the week of the inspection and had shown overall positive results.

Patients completed questionnaires throughout the treatment pathways and staff at discharge asked patients how they found the procedure and if they were satisfied with the care they received.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

The service showed that there was a culture of continual learning and that their staff looked to continually improve. This was shown through the reporting and investigation of both incidents and complaints and how learning was shared.

The provider's corporation was part of the international medical advisory board, this was an independent board made up of experts of ophthalmology. This board gave a platform to discuss outcomes and future initiatives to improve patient outcomes in the future.

Good

Refractive eye surgery

The service employed a biostatistician to review Ophthalmologist outcomes, these results were used by the service so that the services Ophthalmologist could discuss these outcomes and determine areas for improvement.