East Midlands Medical Services

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Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 16 March 2018 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led.

Our findings were:

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations

Background

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

East Midlands Medical Services is a community eye service specialising in the provision of on-going testing and management for patients with glaucoma, in addition to a new paediatric service specialising in the management of lazy eyes, squints and children who need glasses. These services are funded by the NHS and patients are referred to the service from a local hub following a GP assessment.

East Midlands Medical Services is registered with the Care Quality Commission to provide services from an optometrist at 190 Wollaton Road, Nottingham NG81HJ. The provider has been registered to provide services since 21 June 2013.

The staff work primarily within other services and on average work one day a week on a scheduled basis within this service, depending on demand and availability. The clinic offers appointments at the following times, this can be extended depending on demand:

- Monday to Friday 9am until 5pm

Summary of findings

- Saturday 9am until 4.30pm

The main workforce consists of two ophthalmologists, four optometrists, two orthoptists, and two administrative staff. The service utilise a room within an opticians and have a safe storage area for records and equipment within the site. All patient treatment rooms are on the ground floor and there is an accessible disabled toilet and baby changing facilities available. There are some parking spaces available on the shop front and it is located on a bus route.

One of the optometrists is the registered manager and works within the service. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

As part of our inspection we reviewed 18 CQC comment cards where people provided feedback about the service. All of the 18 comment cards we received were extremely positive about the care and treatment received. Patients described the service as efficient, praised the location for being clean and bright, and the clinicians as professional, polite and caring. Patients also complimented the appointment system and the fact that the service always ran on time.

Our key findings were:

- There was a system in place for managing unintended incidents.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. The provider followed NICE guidelines to ensure clinical practice was up to date and to drive improvement.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients were positive about the care they received and the way in which it was delivered.
- The practice proactively sought feedback from patients after the consultation and on an annual basis by a telephone questionnaire.
- There were Saturday appointments available from 9am to 4.30pm for those unable to attend appointments in the week.
- There was a system in place for monitoring complaints and we saw an historic complaint, which was effectively managed, the patient responded to in a timely manner and apologies given when appropriate.
- There was a clear leadership structure and staff felt supported by the partners

We identified regulations that were not being met and the provider must**:**

- Ensure care and treatment is provided in a safe way to patients. (For details, please refer to the requirement notice at the end of this report)
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. (For details, please refer to the requirement notice at the end of this report)

There were areas where the provider could make improvements and should:

- Review the procedure for updating staff in relation to policy changes.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations.

- The arrangements in place to safeguard children and vulnerable adults did not reflect the relevant legislation and local requirements. The provider had not assured themselves that all clinicians had the relevant level of safeguard training.
- The service had been managing glaucoma until recently when it had also begun to provide paediatric eye care under a new contract. Following this change in the provision of paediatric eye care, there had been no change to protocols to assure staff the adult accompanying the child had parental authority.
- A legionella risk assessment had not been undertaken.
- The practice did not have equipment or medicines on site to manage medical emergencies, such as oxygen or a defibrillator. The provider had not risk assessed the need for such equipment.
- We were told during the inspection that there was no system in place to check or record medicine fridge temperatures on a daily basis.
- There were effective recruitment processes in place and all members of staff had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff who acted as a chaperone were trained to carry out this role and had a DBS check in place.
- If there was an unintended or unexpected safety incident, patients would receive reasonable support, truthful information and a verbal and written apology. They would be told about any actions to improve processes to prevent the same thing happening again
- The practice held records of Hepatitis B status for clinical staff who had direct contact with patients' blood for example through use of sharps.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

- Regular clinical audits were used to review the way in which care was delivered and to ensure it was based on NICE guidelines.
- The service had not assured itself all members of staff were suitably trained to carry out their roles
- There was evidence of appraisals, however there was no formal induction process established to support new staff in carrying out their role.
- The practice shared information with NHS GP services and general NHS hospital services when necessary and with the consent of the patient.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

- Patients said they were treated with dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available to them was easy to understand and accessible.

Summary of findings

- Since beginning the provision of paediatric services, the provider had created age appropriate information boards and purchased toys to make the reception feel welcoming.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Patients were encouraged to complete feedback forms and surveys through a variety of formats.

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

- Appointments were sometimes available on the same day and capacity adjusted to meet demand.
- There were Saturday appointments available from 9am to 4.30pm for those unable to attend appointments in the week.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand.
- Telephone translation services were available for patients whose first language was not English. This ensured patients understood their treatment options.
- A new website was in development to explain the service and to provide health advice.

Are services well-led?

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations

- Governance of the service was not effective, due to the recent expansion of the service and the associated employment and provision of care to children, adequate policies and safeguards had not been put in place.
- The service had not identified and mitigated some risks to patients and staff. For example, there were no risk assessment for legionella and no system in place for the storage of medicines in the fridge.
- The service had a clear philosophy and strategy to provide the highest level of eye care, in a community setting to the benefit of the patients and the NHS. Staff were clear about the vision and their responsibilities in relation to this.
- There was a clear leadership structure and staff felt supported by management.
- The service proactively sought feedback from patients and we saw examples where feedback had been acted on. There were development plans for a patient participation group to assist in future decisions and changes.
- The service engaged with stakeholders with a view to improving performance.

East Midlands Medical Services

Detailed findings

Background to this inspection

The following inspection was carried out on 16 March 2018. Our inspection team was led by a CQC Lead Inspector and was supported by a GP Specialist Advisor. Prior to the inspection we had asked for information from the provider regarding the service they provide.

During our visit we:

- Spoke with the lead optometrist.
- Reviewed the personal care or treatment records of eight patients.
- Reviewed 18 CQC comment cards where patients and members of the public share their views and experiences of the service'.
- Reviewed documents and systems.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The provider was aware of, and complied with the requirements of the Duty of Candour and encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents. There had been one incident reported in the preceding 12 months

From this incident we saw that:

- The service gave the affected person reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.
- There was an effective system in place for reporting and recording significant events.
- We were told significant events were discussed in monthly meetings and we saw minutes where this was the case, and there had been peer learning following the investigation to reduce the risk of reoccurrence.
- We saw evidence of a serious incident reporting policy.
- The provider held a record of significant events which included details of investigations and actions taken as a result of the significant event.

The practice had signed up to the Medicines and Healthcare Products Regulatory Agency (MHRA) website to enable alerts to be received. These were reviewed by the registered manager who took the necessary action, and disseminated to the team by email.

Monitoring risks to patients

The practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, for example:

- The arrangements in place to safeguard children and vulnerable adults did not reflect the relevant legislation and local requirements. The provider had not assured themselves that all clinicians had the relevant level of safeguarding training and there had been the assumption that they had the qualification in their primary role at the local NHS Trust.
- The service had been managing glaucoma until recently when it had also begun to provide paediatric eye care under a new contract. There had been no change to protocols to assure staff the adult accompanying the child had parental authority.
- The lead ophthalmologist was the safeguarding lead and staff were aware of who to contact if they were not available. The policies, which were accessible to all staff, clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Relevant contact details were easily available to staff in their work areas and a copy was kept in all clinical rooms.
- We were informed that there had been no safeguarding referrals made by staff as there had been no concerns identified.
- The clinic did not hold a database of patients and therefore no safeguarding alert was visible on the patient record to alert staff. However, we were assured that staff knew what to do if they suspected a safeguarding concern.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- We reviewed the provider's central recording system and saw that all three members of staff who worked at the Wollaton clinic had received appropriate recruitment checks prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.
- We saw evidence of medical indemnity insurance for all staff working for the service.
- There was a comprehensive health and safety policy in place which was accessible to all members of staff electronically. However, there was no effective oversight of the status of staff training for areas such as fire safety, basic life support, infection prevention and control, moving and handling, safeguarding adults and children, information governance, equality and diversity, complaints handling and lone working.This was an area

the provider was working to address, with the implementation of an online training provider and all staff would be required to complete training the provider considered mandatory.

- The service had adequate fire safety equipment in place and all equipment had been serviced on a regular basis. A risk assessment had been completed and a fire action notice was visible to patients and staff telling them what to do in the event of a fire. There was a designated fire marshal at the optometrist and regular fire drills had been conducted.
- Records were held on site that showed all electrical and clinical equipment had been checked by an accredited external contractor.
- The provider had secure storage for patient records and only staff for the service had access to this part of the building. Confidentiality training had been completed by all staff at the optometrist as well as the provider.
- The provider used an e-mail system and all electronic mail was encrypted for maximum security.
- The registered manager was the infection control lead. Although there had been some training provided for staff, there was no oversight of the currency of this training and there was no formal induction procedure to cover areas such as hand washing and infection control.
- There was a regular infection control audit completed and we saw changes made as a result of the subsequent action plan.
- The provider maintained appropriate standards of cleanliness and hygiene. We observed the premises to be very clean and tidy. There was a process in place to ensure a cleaning and monitoring checklist was completed and signed on a daily basis for each area of the premises.
- Staff were routinely offered influenza and Hepatitis B vaccinations throughout their employment. We saw evidence of Hepatitis B status for clinical staff members who had direct contact with patients.
- Suitable processes were in place for the storage, handling and collection of clinical waste.
- A legionella risk assessment had not been undertaken and the provider was aware one was required.

Appropriate and safe use of medicines

The systems in place for managing medicines were not in line with best practice guidelines. Not all medicines were stored appropriately.

- We were told during the inspection that there was no system in place to check and record medicine fridge temperatures on a daily basis. We saw no evidence of a cold chain policy in place (cold chain is the maintenance of refrigerated temperatures for medicines).
- All prescriptions were issued on a private basis and were printed individually by the service during consultation.
- The service carried out audits of medicines.
- We saw evidence that a monthly stock check was carried out on all medicines to ensure they were in date.
- The practice did not have equipment or medicines on site to manage medical emergencies, such as oxygen or a defibrillator. The provider had not risk assessed the need for such equipment.

Are services effective?

(for example, treatment is effective)

Our findings

Assessment and treatment

The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines, and The Scottish Intercollegiate Guidelines Network (SIGN) (Both of these organisations are responsible for providing national guidance in the UK on the promotion of good health and the prevention and treatment of ill-health.)

The provider was committed to ensuring patients received the most up to date care, and worked within the remit of national guidance for the treatment and management of patients conditions.

Four record audits had been undertaken over an 18 month period; each reviewed 10% of the most recently seen patients' records. The most recent audit showed 96% of patients had the appropriate recalls in place and 88% of patients were being treated according to NICE guidelines. The clinic took actions as a result of the audit, and through team meetings, changes were implemented, such as guidance being reviewed as a team and the increased adherence to NICE guidance, and improved note taking assessed through future audits.

The current paper based records were not conducive to regular searches and audits and this was an area being reviewed.

Staff training and experience

The provider did not have a comprehensive induction and training programme in place for newly appointed staff. There was an induction process in development at the time of our inspection and this was planned to be released two months following the inspection.

We were told staff would be supported during the initial month, and once the online training package was in use all staff would be expected to complete this during the initial phase of their employment. However, there was not currently any formal documentation to support this. The provider was unable to provide evidence of staff training and staff employed by the service were assumed to have completed such topics as safeguarding, infection prevention and control, information governance, chaperone, health and safety hand washing techniques, fire safety, basic life support, complaints handling and confidentiality in their primary employment.

Staff were provided with some ongoing training in conjunction with the local Clinical Commissioning Group (CCG), such as safeguarding; however ongoing training for staff was expected to be delivered outside of the service by employees' primary employment. There was currently no oversight of training by the provider.

The learning needs of staff were identified through a system of appraisals completed by the registered manager; we saw evidence that all staff had received an appraisal within the last 12 months.

Working with other services

We saw evidence of thorough and detailed assessments recorded in patients' paper records, which were available to relevant staff. This included care assessments, consultation records, and investigation and test results.

The service ensured sharing of information with NHS GP services and general NHS hospital services when necessary. For patients being referred to secondary care, paper records were scanned and a covering letter sent digitally to the clinical hub to be sent to the appropriate team, with a copy being sent to the registered GP. To ensure a GP was informed of ongoing treatments or test results within the service letters were sent directly to the GP, this ensured the patient's central clinical record was up to date.

At our inspection, we saw a number of examples of how information was shared with NHS GPs and other health professionals, both directly and through clinical hub.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. The practice had a consent policy in place;

- Before patients received any care or treatment, they were asked for their consent and the provider acted in accordance with their wishes.
- The registered manager told us that any treatment was fully explained prior to the procedure and that people then made informed decisions about their care.

Are services effective?

(for example, treatment is effective)

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. However, the identity of a child was not routinely checked prior to treatment.
- The practice offered Language Line interpreter services as an additional method to ensure that patients understood the information provided to them prior to treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- We noted that consultation room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All staff had received training in confidentiality, including the optician staff who had contact with the service's patients. Staff we spoke with understood the importance of confidentiality and the need for speaking with patients in private when discussing services they required.

Involvement in decisions about care and treatment

Patient feedback on the 18 comment cards we received told us they felt involved in decision making about the care and treatment they received. They also told us they never felt rushed during a consultation and felt listened to.

The provider encouraged patients to provide feedback at the end of consultations. In 2017, the provider had conducted a telephone survey with 38 patients of which 23 responses were obtained. In the survey:

- 100% of patients who responded told the provider they were treated in a courteous way.
- 100% of patients who responded told the provider they were happy with the service they received.

We reviewed eight patient records and saw that a comprehensive assessment had been made that included a risk assessment, explanation of treatment and confirmation of patient consent.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

- The premises, from which the service was provided, was accessed from the main street, with parking for several vehicles available outside.
- Since commencing the paediatric services, the provider had created age appropriate information boards and purchased toys to make the reception feel welcoming.
- The reception, waiting area and all consulting rooms were on the ground floor.
- There was a disabled toilet and baby changing facilities available for patients' use.
- Language Line telephone translation services were available for patients whose first language was not English. This also ensured patients understood their treatment options.
- Written information was available to patients in other languages. Information for patients was available in Braille and large print for patients who were blind or suffered with poor vision.
- Health promotion information was available for patients in the waiting room.
- A new website was in development to explain the service and give health advice.
- A water dispenser was available for patients in the reception area.

Tackling inequity and promoting equality

The service organised appointments for all patients who were referred through the CCG hub. These referrals came from local GPs and from secondary care. The service did not discriminate against any client group. There were disabled facilities and translation services available.

Access to the service

The service was available from 9am to 5pm Monday to Friday and 9am to 4.30pm on a Saturday. Clinics were organised based on demand and additional sessions planned as required.

Concerns & complaints

The service had an effective system in place for handling complaints and concerns.

Its complaints policy and procedures were in line with recognised guidance. The registered manager was the designated responsible person who handled all complaints.

The complaints procedure was available to help patients understand the complaints system. There was information on how to complain in the patient waiting area.

We were informed that there had been no complaints received in the last 12 months. We reviewed one complaint, which was two years old and saw the complaint had been acknowledged in writing and we found they were satisfactorily handled and dealt with in a timely way. The service demonstrated an open and transparent approach in dealing with complaints.

When lessons were learnt from concerns and complaints, they would be discussed and shared during monthly meetings and disseminated by email for those clinicians who could not attend.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

Governance arrangements

The service did not have an overarching governance framework to support the delivery of the strategy and good quality care.

There were some structures and procedures in place however there were elements of governance that were not effective:

- The provider ensured continued professional registration through 'continued professional development' (CPD). However during the inspection the provider was unable to show evidence staff had the competence or skills required to undertake the role, for example safeguarding training.
- The recruitment and selection procedure was informal and the process did not support the provider in demonstrating suitability of candidates.
- With the recent expansion of the service, systems had not been put in place to enable clinicians to assure themselves the person accompanying a child had parental authority.
- The service had clinic specific policies, which were implemented and available to staff, however, there was no record that staff had read them.
- The assessment and treatment of patients was in line with the NICE guidelines and there were audits to in place to ensure these were followed.

Leadership, openness and transparency

There was a clear leadership structure which staff were aware of:

- The clinicians in the service were unable to demonstrate they had the experience, capacity and capability to run the service with patients' safety in mind.
- We saw there was an open culture within the service and staff had the opportunity to raise any issues and felt confident in doing so and felt supported if they did.
- Due to the varied working pattern of staff there was limited opportunity for formal staff meetings where staff could to be involved in discussions about how to run and develop the practice. However the registered manager encouraged all members of staff to identify opportunities remotely to improve the services delivered by the service.

Learning and improvement

The registered manager had undertaken appraisals and highlighted areas where staff wished to develop and plan further training. As a partnership, there was a strong vision for developing the service and providing the highest level of eye care in the community.

The leadership team had found two additional sites from which to operate the service and allow for greater accessibility for patients. Additional recruitment was underway and systems being put in place to support staff delivering care over multiple sites.

We saw evidence of case anonymised case reviews, which were shared with staff which included positive summaries showing best practice to share learning. These enabled reflective practice and improvements in clinical practice.

There were monthly partner meetings where all aspects of the service were reviewed and these were minuted.

The service encouraged feedback and offered patients the opportunity to reflect on their experiences in a number of ways, including paper questionnaires after consultations and by telephone questionnaires conducted every year.

Provider seeks and acts on feedback from its patients, the public and staff

The service encouraged and valued feedback from patients and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. The service had gathered feedback from patients through surveys and had begun to engage with patients to establish a patient's participation group to further develop the way in which care was delivered.

The service had also gathered feedback from staff through staff meetings and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the service was run.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 – Safe care and Treatment** **Regulation: Regulation 12(1)** **Care and treatment must be provided in a safe way for service users to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **How the regulation was not being met:** • There was no risk assessment for legionella • **There was no assessment of risk in relation to having appropriate emergency medicines or equipment in place.** • **There was no process in place for the management or monitoring of the cold chain.** • There was no system in place to validate the training staff had completed, for example safeguarding.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 – Good governance** **Regulation 17(1)** **Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014**

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

There were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- There was no system in place to ensure staff had completed adequate training for their role.
- There was no system in place to ensure staff had read policies once they had been reviewed or updated.
- There was no system in place for a formal induction.
- There was no system in place to ensure adults accompanying children had parental authority.