Eagle Eyecare Limited

# Eagle Eyecare Limited

**Inspection report**

194 Totley Brook Road
Sheffield
S17 3QY
Tel: 01143480781

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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 | Inspected but not rated |
| Are services safe? | Inspected but not rated |
| Are services well-led? | Inspected but not rated |

# Summary of findings

## Overall summary

We did not rate this service.

The CQC carried out a responsive follow up inspection at Eagle Eyecare Limited on 30 June 2021. This inspection was undertaken following a notice of decision served to the provider under section 31 of the Health and Social Care Act 2008.

The Section 31 notice of decision was served in April 2021 and required the provider to immediately suspend the carrying out of regulated activities at the registered premises and from satellite locations including 'The Surgery@Wheatbridge'.

We undertook this inspection to review progress the provider had taken to address the concerns we had identified.

At this inspection we found that the service did not have the leadership and management to effectively run the service; we had concerns about the oversight the registered manager had in the running of the service.

There was an absence of underpinning governance arrangements and audits to ensure patient safety and determine patient outcomes.

The arrangements for the service to use facilities at the 'Surgery@Wheatbridge' were unclear and there was no service level agreement.

We did not find evidence the registered manager ensured staff were competent through the provision of training and development. Staff were also unclear about their roles, responsibilities and accountabilities.

We did not find evidence that patients had come to harm. However, we were concerned that patients were exposed to the risk of harm.

Following this inspection, under Section 31 of the Health and Social Care Act 2008, we suspended the provider in respect to the regulated activities for a further time limited period to give the provider opportunity to take action to reduce and mitigate the risks. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Surgery** | **Inspected but not rated** | We did not rate this service.<br>Staff did not have training in key skills, understand how to protect patients from abuse, or manage safety well. The service did not control infection risk well. Staff did not assess risks to patients, act on them or keep good care records. The service did not manage safety incidents well and learn lessons from them. Staff did not collect safety information and use it to improve the service.<br>The registered manager/clinician did not monitor the effectiveness of the service and did not make sure staff had the skills and competence to undertake their roles.<br>The registered manager/clinician did not run services well using reliable information systems and did not support staff to develop their skills. Staff were unclear about their roles and accountabilities.<br>However, people could access the service when they needed it and did not have to wait too long for treatment. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. |

# Summary of findings

## Contents

# Summary of this inspection

## Background to Eagle Eyecare Limited

The service provides ophthalmic diagnostic and eye treatment services for the treatment of glaucoma and cataract.

The service is registered for treatment of disease, disorder or injury, surgical procedures and diagnostic and screening procedures.

A transitional monitoring approach call was held with the service on 22 February 2021. This call raised concerns about the management of the service and the safety of patients. In response, a focused inspection was undertaken in April 2021 resulting in the suspension of regulated activities.

Throughout this report 'registered manager/clinician' is used to refer to the owner of the business and their wider roles and responsibilities as registered manager.

The service has registered premises at 194 Totley Brook Road, Sheffield, S17 3QY and undertakes consultation and diagnostic services at a local general practitioner premise, the 'Surgery@Wheatbridge', under licence from the property owner. This is referred to as 'the surgery' throughout this report.

The service has not been inspected since registration in August 2017.

## How we carried out this inspection

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

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the service MUST take to improve:**

We told the service that it must take action to bring services into line with the following legal requirements. This action related to treatment of disease, disorder or injury, surgical procedures and diagnostic and screening procedures:

- The service must ensure that mandatory training in key skills is available, particularly safeguarding, to all staff (Regulation 12 (1));
- The service must develop processes to assess and record the risks to the health and safety of service users of receiving the care or treatment (Regulation 12 (1));
- The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided (Regulation 17 (1)(3));

# Summary of this inspection

- The service must develop a service level agreement with the owner of the premises used by the service to ensure they are safe to use for their intended purpose and are used in a safe way (Regulation 12 (1));
- The service must ensure systems or processes are established and operated effectively to ensure compliance with the requirements to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities (Regulation 17 (1)(3));
- The service must ensure systems or processes are established and operated effectively to ensure compliance with the requirements to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activities (Regulation 17 (1)(3)); and
- The service must ensure systems or processes are established and operated effectively to ensure staff are recruited in full accordance with Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA regulations).

**Action the service SHOULD take to improve:**

We told the service that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

- The service should ensure that it adheres to government Covid-19 guidance, by reviewing or updating any of their policies or patient pathways accordingly (Regulation 12); and
- The service should ensure the employment status of staff including the senior patient advisor, clinical secretary and housekeepers is clarified (Regulation 17).

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Surgery | Inspected but not rated | Not inspected | Not inspected | Not inspected | Inspected but not rated | Inspected but not rated |
| Overall | Inspected but not rated | Not inspected | Not inspected | Not inspected | Inspected but not rated | Inspected but not rated |

Inspected but not rated

# Surgery

| | |
|---|---|
| Safe | Inspected but not rated |
| Well-led | Inspected but not rated |

## Are Surgery safe?

Inspected but not rated

We did not rate safe.

**Mandatory training**

The service did not provide mandatory training in key skills to all staff.

During our previous inspection staff told us they did not complete mandatory training in any modules.

We were not provided either before or during this inspection with any plans to develop and implement mandatory training in key skills for current or future staff.

We were not assured the service had identified and ensured staff were up to date with mandatory training requirements.

**Safeguarding**

At our previous inspection staff did not understand how to protect patients from abuse and the service did not work well with other agencies to do so. Staff had not received training on how to recognise and report abuse and they did not know how to apply it.

Staff had not received effective training in safeguarding systems, processes and practices.

Prior to this inspection we were provided with an 'Aims of Safeguarding Adults Statement' and a 'Zero Tolerance Statement'. These outlined the aims of safeguarding adults, the expectation and principles applied to staff at Eagle Eyecare Limited, and confirmed the service would have a zero-tolerance approach to anyone who abused staff or other patients.

However, the service had not developed and implemented a specific safeguarding policy that identified a nominated safeguarding lead within the service and that contained clinical commissioning group and local authority safeguarding contacts.

This put service users at risk of harm because there was no clear guidance for staff for the actions they needed to take in response to suspicions and allegations of abuse.

There was no evidence the service had developed systems and processes to investigate any allegation or evidence of abuse.

Inspected but not rated

# Surgery

We were not assured systems and processes had been developed to ensure staff were aware of the definitions of abuse, how to recognise abuse, local safeguarding guidance and reporting procedures to fulfil their role in safeguarding children and adults at risk.

**Cleanliness, infection control and hygiene**

At our previous inspection the service did not control all infection risks well. Staff did not use records to identify how well the service prevented infections, and staff did not follow infection control principles including the use of personal protective equipment (PPE).

Prior to this inspection we were provided with procedures for staff assessment of risk associated with treatments and the need for personal protective equipment. The service also provided a 'Standard Infection Control Policy', 'Personal Protective Equipment', an 'Infection Control Statement' and a 'Hand Hygiene Statement'.

However, the service had not developed systems and procedures to identify and prevent post-operative infections. A system had not been developed to monitor how many patients had subsequently been for follow up appointments or treatment related to surgical site infections.

We were not assured that all infection risks to patients were identified and managed.

**Environment and equipment**

At our previous inspection the design, maintenance and use of facilities, premises and equipment did not keep people safe.

We told the service it must develop arrangements with the owner of the premises used by the service to ensure they were safe to use for their intended purpose and were used in a safe way.

We were not provided with an updated licence agreement, details of any arrangements or a service level agreement.

The current licence agreement did not include provision for any services to be provided by the owner of the premises or the surgery. At this inspection we were told all equipment used by the service had been removed from the premises.

We were not assured that systems and procedures were in place to ensure the design, maintenance and use of facilities and premises are safe to use for their intended purpose.

**Assessing and responding to patient risk**

At our previous inspection staff did not complete and update risk assessments for all patients and did not remove or minimise risks. Staff did not complete risk assessments for each patient on arrival, using a recognised tool, and review this regularly, including after any incident.

The service did not carry out patient risk assessments or develop patient risk management plans in line with national guidance.

Inspected but not rated

# Surgery

Prior to this inspection we were provided with the procedure to be followed in the event of a deteriorating patient and escalation to emergency services ('Management of Deteriorating Patient') and confirmation the service had no restriction regarding gender and only treated adults ('The Service Eligibility Criteria').

However, the service had not developed plans for the completion and review of individual service user risk assessments, and for the inclusion of safer surgery checklists in patient records. The service had not developed a risk management policy.

We did not find evidence the service provided care which reflected evidence-based guidance or standards such as guidance from the Royal College of Ophthalmology or NICE guidance.

Consequently, we were not assured risks were managed appropriately and that staff could identify and respond effectively to changing risks to patients, wellbeing or challenging behaviour.

**Support staff**

At our previous inspection the service did not have 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.

Staff did not undertake mandatory, safeguarding or other training modules or external courses to ensure their competencies.

Prior to this inspection we were provided with the outline role and duties of the senior patient advisor ('Role of the Senior Patient Advisor') and confirmation future recruitment of staff will be in full accordance with Schedule 3 of the Health & Safety Care Act 2008 ('Staff').

However, there were no details how this would be implemented and the procedures that would be applied. We were not provided with details of obtaining and recording documentation relevant to recruitment, for example proof of identity, disclosure and barring service certificates, satisfactory evidence of conduct in previous employment.

We were not provided with a lone working policy.

The service was managed by a registered manager/clinician who was also the nominated individual.

**Medical staffing**

The service had enough staff with the right qualifications, skills, training and experience.

Consultations and diagnostic assessments were carried out at the surgery.

The registered manager/clinician was the main surgeon at the service. They carried out all surgery undertaken by the service under practising privileges at local independent hospitals.

We saw the registered manager/clinician's proof of practising privileges to undertake surgery at the local independent hospital.

Inspected but not rated

# Surgery

**Records**

Staff did not keep detailed records of patients' care and treatment. Records were not clear and up to date. Records were not stored securely.

However, prior to this inspection we were provided with a policy outlining the creation, retention, security and destruction of patient records to be adopted within the service ('Health Record Management Policy').

A 'record keeper' would be employed by the service and present at the registered address, providing additional security.

The service did not undertake patient note reviews or audits, or any clinical governance to gauge how thorough and fully completed notes were to ensure best practice or quality improvement. However, we were provided with plans to audit patients files held at the registered address, every three months. Audits intedned to ensure that all the information has been recorded for each patient, for example registration form, examination/continuation sheet, investigations and findings, biometry.

**Medicines**

The service did not use systems and processes to safely prescribe and administer medicines.

The service provided a medicines policy (November 2018) prior to our previous inspection.

At this inspection the registered manager/clinician confirmed the service intended to use new eye drops, which didn't need fridge storage and could be kept at room temperature.

**Incidents**

The service did not manage patient safety incidents well.

At our previous inspection the service did not have a policy or process in place for staff to report or monitor incidents. There were no agreed identifiable criteria on what constituted a notifiable serious incident (SI) both for the service or to report to other bodies.

Prior to this inspection we were provided with the procedure to be followed in the event of a deteriorating patient and escalation to emergency services ('Management of Deteriorating Patient'). This included informing surgery staff to enable them to '…co-ordinate the arrival of an ambulance and ambulance staff'.

At this inspection the registered manager/clinician confirmed there was no service level agreement in place which would cover the notification and response by surgery staff to never events or serious incidents that occurred at the service.

There were no never events or serious incidents reported by the service during the twelve months before inspection.

## Are Surgery well-led?

Inspected but not rated

# Surgery

Inspected but not rated

We did not rate well-led.

**Leadership**

Leaders did not have the skills and abilities to run the service. They did not understand and did not manage the priorities and issues the service faced. They did not support staff to develop their skills.

The service was led by the registered manager/clinician, who was also owner of the business and the main surgeon. They were responsible for the governance of the service, as well as providing care and treatment to patients. Their management of the service was supported by a senior patient advisor and an administrator/clinical secretary.

The registered manager/clinician was unable to demonstrate full understanding of their responsibilities in carrying out or managing regulated activities and meeting the standards required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA regulations).

During our monitoring call in February 2021, the senior patient advisor discussed the consultation, diagnosis and treatment of patients. At our previous inspection, patients were listed for consultation and diagnostics on the same afternoon. However, the registered manager/clinician stated the service had never had any patients.

We had asked for details of these patients and in what capacity they are being seen as the arrangements to see patients at the surgery was unclear.

At this inspection, the registered manager/clinician stated patients were being seen under an undocumented practising privileges arrangement. Further, documentation related to patients was branded under the name of a separate and unregistered company, 'on behalf of EEC Limited'.

The registered manager/clinician was unable to confirm the registered provider who was carrying out regulated activities at the surgery. They were also unable to confirm support arrangements with them through the provision of a documented arrangement or a service level agreement.

Following our previous inspection, we requested audits, policies, procedures and protocols, for example . patient outcome audits, safeguarding policy, patient safety checklist and audit, patient records audit, patient needs assessment, MCA policy, consent policy and consent audit, risk management policy and risk register. These have not been provided.

**Vision and strategy**

The service had a vision for what it wanted to achieve. However, this had not been applied to the operation of Eagle Eyecare Limited.

For example, we were not provided with information that showed the service had '…provided the best possible ophthalmic service to its patients' by providing adequate facilities, good staffing levels and appropriate managerial support.

Inspected but not rated

# Surgery

In the absence of outcome audits the service could not show it provided '…ophthalmic patients the same or better choice of care than that currently provided by existing qualified providers'.

During our previous inspection and this inspection, we have not received assurance the service has complied with all regulations and the Health and Social Care Act 2008.

**Culture**

At our previous inspection staff said they felt respected, supported and valued. They were focused on the needs of patients receiving care.

However, we were told the registered manager/clinician lacked day to day accountability for the service and its staff.

During this inspection, we were unable to speak to staff other than the registered manager/clinician.

**Governance**

Leaders did not operate effective governance processes throughout the service. Staff at all levels were unclear about their roles and accountabilities and did not have regular opportunities to meet, discuss and learn from the performance of the service.

We asked for written or recorded policies, procedures or documentation prior to inspection and also at inspection. We received some of the requested documentation, but some did not contain the detail necessary to give assurance about their implementation, for example future recruitment in full accordance with Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA regulations).

We have not received other requested documentation, for example comprehensive patient lists that contain details of when patients were seen. The registered manager/clinician did not know how many patients had been seen in the previous 12 months

During this inspection, we were given assurance that further documentation would be provided, for example latest annual patient files audit, equipment cleaning checklist, practising privileges with Eagle Eyecare Limited, practising privileges with an independent hospital, staff CVs (at the time of registration), service level agreement with an independent hospital, an action plan for 'safety checks', best guidance referenced in policies, new contract for equipment maintenance, and patient's initial assessment form.

These have not been provided.

The service provided policies that had the name of another company on behalf of Eagle Eyecare Limited. The registered manager/clinician told us this had been a mistake on the policies. We were not assured governance processes the service had in place reflected the service provided.

We saw details within the healthcare records management policy that identified records at the registered location would have a 'record keeper, 24/7.' However, we were not assured this reflected the current service provision as during the inspection, the registered manager told us no staff were currently employed in the service.

Inspected but not rated

# Surgery

A service level agreement was not in place with the landlord of the premises of the surgery, which would outline expected standards, monitoring and review arrangements in communal areas. This puts service users at risk of harm because in the event of accident or injury onsite, as staff would not know who was responsible or accountable.

**Managing risks, issues and performance**

Leaders and teams did not use systems to manage performance effectively. They did not have plans to cope with unexpected events.

Before this inspection we were provided with documentation that identified the current risks at the registered address associated with running the service ('Risk Assessment'), identified the current risks at the registered location associated with running the service, identified the current risks at the registered location associated with running the service ('Risk Assessment') and identified how the service will meet its duty of care to patients and staff (and others) by creating a culture of undertaking risk assessments ('Risk Assessment Eagle Eyecare').

The service has not provided plans to carry out clinical or individual risk assessments for service users. This put service users at risk of harm as they may receive care and treatment which does not meet their needs.

The service did not provide policies or protocols to monitor or audit patient outcomes post-operatively. This meant the service could not compare their performance or clinical effectiveness to other similar services.

**Managing information**

The service did not collect and analyse reliable data. Staff could not find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

At this inspection we were unable to identify up-to-date and comprehensive information on all patients' care and treatment. We were told policies and procedures were stored on electronic systems in the registered premises, but we could not corroborate this.

We were not assured patient information and records were stored safely and securely in lockable cabinets, in line with the Data Protection Act 2018.

**Engagement**

Leaders and staff actively and openly engaged with patients. They did not collaborate with partner organisations to help improve services for patients.

Before inspection, we were provided with the procedure for conducting patient satisfaction surveys after appointment ('Patient Outcome Audits').

This indicated it would be distributed by another company (not CQC registered) also run by the registered manager/ clinician, on behalf of Eagle Eye Care.

We requested, but were not provided with completed audits of patient feedback.

Inspected but not rated

# Surgery

We were unable to identify any service improvements resulting from patient feedback.

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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose<br>**The service was putting service users at risk of harm because they may receive care and treatment inappropriate to their individual needs.** |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br>**The service was putting service users at risk of harm through a potential lack of recognition of safeguarding issues and inappropriate responses due to unclear processes and procedures.** |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**Service users were at risk of harm because care and treatment was provided without full and complete service user records and procedures to measure the effectiveness of treatment.** |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed |

This section is primarily information for the provider

# Requirement notices

| | |
|---|---|
| Treatment of disease, disorder or injury | The service exposed service users to the risk of harm through a lack of evidence that staff are suitably qualified, competent, skilled and experienced. |

This section is primarily information for the provider

# Enforcement actions

## 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<br>Surgical procedures<br>Treatment of disease, disorder or injury | S31 Urgent suspension of a regulated activity<br>The provider must immediately suspend the carrying out of regulated activities from 5 July 2021 until 5 October 2021 at or from the following location:<br>Eagle Eyecare Limited, 194 Totley Brook Road, Sheffield, South Yorkshire, S17 3QY;<br>and from satellite locations including the following:<br>'The Surgery@Wheatbridge', 30 Wheatbridge Road, Chesterfield, Derbyshire, S40 2AB. |