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.

We found that the service did not have the leadership and management to effectively run the service; we had concerns about the involvement of the registered manager 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 in the absence of a 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 and accountabilities.

However, we did not find evidence that patients had come to 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 limited time period to give the provider opportunity to take action to reduce 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. 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. The registered manager/clinician did not monitor the effectiveness of the service and did not make sure staff had the skills and and competence to undertake their roles. The registered manager/clinician did not run services well using reliable information systems and did not support staff to develop their skills. Despite our requests we were unable to speak with the registered manager as part of this inspection. Staff were unclear about their roles and accountabilities. The service did not engage well with patients and the community to plan and manage services. 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.

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));
- 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));

Summary of this inspection

- The service must ensure that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way (Regulation 12 (1));
- The service must ensure all equipment used by the service is properly maintained (Regulation 15 (1)(2));
- 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 inspection staff told us they did not complete mandatory training in any modules.

This applied to, for example, a lack of training in adult and/or child safeguarding, infection control, learning disabilities and dementia awareness.

Although the surgery had mandatory training available online, there was no agreement for access to this service. Staff told us they were discouraged from accessing or printing files remotely.

Staff told us their training was given when and as needed by the registered manager/clinician.

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

Safeguarding

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.

Although staff described how they would raise any safeguarding concerns, they did not know when or how to report any safeguarding concerns on behalf of vulnerable patients.

They told us they would leave any safeguarding issues to the registered manager/clinician.

Although the service had obtained the adults safeguarding policy developed by the surgery, it had not been amended to reflect the risks of harm for their own patients. Staff had not assessed its effectiveness as the policy had never been used or implemented.

This policy did not identify a nominated safeguarding lead within the service.

Inspected but not rated

Surgery

The policy did contain clinical commissioning group and local authority safeguarding contacts.

We were not assured 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.

There were no safeguarding concerns reported to CQC in the twelve months before inspection.

Cleanliness, infection control and hygiene

The service did not control all infection risks well. Staff did not use records to identify how well the service prevented infections.

Staff did not follow infection control principles including the use of personal protective equipment (PPE).

The service did not record patient and staff temperature checks on arrival, or maintain any individual staff risk assessments.

Although personal protective equipment (PPE) was available at the entrance to the surgery reception, as well as handwashing facilities and sanitising hand gel, during inspection staff did not wear PPE correctly in the surgery or registered office locations. Staff kept touching and adjusting their mask which was often beneath their nose or did not cover their nose or mouth.

The service did not adhere to government Covid-19 guidance, by reviewing or updating any of their policies or patient pathways accordingly.

Although, staff told us patients had not reported post-operative infections, the service did not provide evidence of systems in place to identify and prevent post-operative infections.

We were not assured that all infection risks to patients were identified and managed. A system was not in place to monitor how many patients had subsequently been to their GP, local hospital's accident and emergency department or other services for follow up appointments or treatment as a result of surgery.

The service did not have a policy for infection control in place.

Staff cleaned equipment after patient contact.

Staff told us all patients take a lateral flow test before attending their appointment.

The clinical secretary called patients before their appointments to ensure they had no Covid-19 symptoms. We were provided with a list of screening questions for patients, to assure they were not COVID-19 positive prior to consultation.

Staff told us the room used at the surgery had the same cleaners as the rest of the building. This was a local cleaning company who maintained a weekly rota cleaning checklist. They would call the surgery's assistant practice manager with any IPC issues.

Environment and equipment

Inspected but not rated

Surgery

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

The service contracted with the building owner to hire a second-floor room at the surgery under a licence agreement. We were provided a copy of the licence agreement; this did not include any provision for services to be provided by the surgery.

The door sign to the room was another company's name (not CQC registered) which was also run by the registered manager/clinician, rather than the registered provider name of Eagle Eyecare Limited.

Although the building and facilities were well maintained and clean, the room was cluttered with expensive ophthalmic diagnostic equipment, a corner desk and three chairs.

The service had no equipment list or schedule in place to ensure equipment was clean and maintained appropriately. Staff told us the registered manager/clinician agreed to order new office equipment when needed, such as their desk.

We reviewed the service's equipment servicing and maintenance contracts. One of these preventative service contracts was almost two years out of date, having expired in June 2019.

Assessing and responding to patient risk

Staff did not complete and update risk assessments for all patients and did not remove or minimise risks. Staff did not use a nationally recognised tool to identify deteriorating patients and escalate them appropriately.

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.

We were not assured risks were managed appropriately and that staff could identify and respond effectively to changing risks to patients, including deteriorating health and wellbeing, medical emergencies or challenging behaviour.

Patient records did not include evidence-based checklists or guidance from national bodies such as the World Health Organisation's (WHO) 'Five Steps for Safer Surgery' checklist, National Institute for Health and Care Excellence (NICE) or the Royal College of Ophthalmologists (RCOphth).

At the time of inspection, staff were unable to provide a risk management policy or a policy for the management and escalation of a deteriorating patient.

However, staff told us they could seek support from senior staff in these situations.

If patients experienced problems out of hours, the service supplied a telephone number for patients to contact the registered manager/clinician.

Support staffing

Inspected but not rated

Surgery

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.

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

This meant the registered manager/clinician could not ensure staff who worked for the service were competent, suitably trained or skilled.

Staff had informal one-to-one meetings with the registered manager/clinician and had not had appraisals. These meetings were infrequent and not documented.

This meant staff had no ongoing or continuous professional development, or wider training opportunities identified to fulfil their management, administrative or secretarial duties.

The service did not have a lone working policy, despite the clinical secretary working in the registered premises alone.

The service was managed by a registered manager/clinician who is 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.

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.

Patient records were filed alphabetically and maintained by the clinical secretary in accordance with the service 'Filing Technique' process (version 1, November 2017) and stored in a cabinet at the service's registered office address. This was a flat that had been the domicile of a relative of the registered manager/clinician.

The keys were only removed from the cabinet to give to the housekeepers who looked after the property 24 hours, and did not leave the property. The service did not employ the housekeepers, so this meant there was a potential information governance breach.

Inspected but not rated

Surgery

The registered manager/clinician collected patient records for that day's appointments from the flat, and returned them later the same day. Staff told us the registered manager/clinician stored patient records in a locked case in transit between locations.

Patient records did not contain pre-assessment checklists, admission screening or eligibility criteria. This meant staff could not assess patient's level of risk or harm from surgery or other care and treatment to ensure they met safe guidelines.

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.

We found inconsistencies in the three sets of patient notes reviewed. For example, the patient's past medical history was only included in one of these three records; the registered manager/clinician had reviewed this past medical history, along with treatments and medications from their GP.

The registered manager/clinician recorded drug and medicines allergies clearly in the patient notes. For example, one record reviewed documented the patient was allergic to topical medicines including glaucoma drops; the registered manager/clinician advised a particular ointment instead, as this was the only drug the patient could tolerate.

The clinical secretary typed up a manual electronic patient record (EPR) to sit alongside the scan images in the same software application.

Medicines

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

The registered manager/clinician performed all patient operations under local anaesthetic. Observations on patients were completed by surgical staff at the independent hospital where operations were performed.

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

Staff checked the medicines stock monthly. At the time of our inspection this was last completed on 31 March 2021.

The only eye drop medicine kept at fridge temperature was a local anaesthetic which expired in the month of our inspection. The service did not monitor or record fridge temperatures.

We also reviewed the service's latest eye drops register; this had not been printed or updated for two years.

Incidents

The service did not manage patient safety incidents well.

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.

Inspected but not rated

Surgery

Staff did not identify examples when they had raised an issue with the registered manager/clinician which had been discussed, analysed or led to service improvement.

This meant if a never event or significant incident occurred, staff may not recognise it as such, which could delay reporting or follow up care potentially putting the patient at risk.

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

Staff were unaware of how many patients had subsequently been admitted to accident and emergency, their GP or caught infections as a result of the service's care and treatment.

However, the registered manager/clinician did record aftercare or follow up advice and treatment in patient notes.

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

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.

We had been unable to contact the registered manager/clinician prior to inspection, during and following the inspection. 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).

These responsibilities were incumbent across their roles as owner and registered manager/clinician.

For example, following inspection the registered manager was unable to confirm the registered provider carrying out regulated activities at the 'Surgery at Wheatbridge' and confirm support arrangements with the 'Surgery at Wheatbridge' through the provision of a service level agreement.

Further, they were unable to provide requested audits, policies, procedures and protocols, e.g. 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.

Inspected but not rated

Surgery

Vision and strategy

The service had a vision for what it wanted to achieve. Leaders and staff did not apply this and monitor progress.

We were unable to contact the registered manager/clinician before or during inspection to discuss their vision and strategy for the service.

However, the service statement of purpose received at the time of registration states:

Eagle Eye Care (EEC) Ltd., is committed to providing the best possible ophthalmic service to its patients;

It will achieve this by maintaining high standards of patient care by providing adequate facilities, ensuring good staffing levels and appropriate managerial support;

EEC team will consist of courteous, dedicated and qualified staff striving to provide the best possible patient centred ophthalmic care;

The purpose is to provide ophthalmic patients the same or better choice of care than that currently provided by existing qualified providers;

Comply with all regulations and guidelines set by the DOH and Care Quality Commission (CQC);

Will provide prompt ophthalmic diagnostic and treatment eye services using cutting edge technology;

EEC will respect every patient's right to confidentiality. In order to strive for improvement, it will offer them a system of feedback;

Maintain and update knowledge and skills by continuing professional development and education of staff.

Culture

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

The registered manager/clinician lacked oversight and day to day accountability for the service and its staff. The registered manager/clinician was unresponsive to repeated requests to contact us.

We were told staff could contact the registered manager/clinician only through a social messenger network and the registered manager/clinician could take up to a week to respond.

Further, we were told the registered manager/clinician picked up post or equipment from the office every two or three weeks.

Staff confirmed (email 18 February 2021) that '…due to the nature of his profession, he is very rarely available and leaves the day to day running of CQC related items to me'.

Inspected but not rated

Surgery

Staff we met were welcoming, friendly, and helpful. Staff were focused on the needs and experience of people using the service.

Staff worked part-time, they spoke highly of the registered manager/clinician and had worked for the service for over five years.

All patients were provided with a 'welcome pack' and the amount and method of payment of fees.

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.

All governanace documentation was stored electronically at the service registered address.

We asked for written or recorded policies, procedures or documentation prior to inspection and also at inspection; the service was unable to provide all requested documentation.

For example, the service did not have a service level agreement (SLA) with either location where they carried out regulated activities - the 'Surgery@Wheatbridge' or the local independent hospital. A SLA sets out the service to be provided, expected standards and monitoring and review arrangements. This meant in the event of the deterioration of a patient, or an accident or injury onsite at these locations, staff would not know who was responsible or accountable.

At the time of our inspection staff told us they had recently updated an agreed escalation response for the surgery waiting room. However, we were unable to locate this in a documents folder or elsewhere on the office computer.

After our transitional monitoring call (February 2021) and subsequent inspection, we requested relevant policies, audits and documentation. The majority of these were not provided.

All the service's patient records were kept at the registered address.

Staff did not complete or provide evidence of any audits.

The service did not undertake clinical governance meetings, meetings with the surgery, or meetings with independent hospitals where treatment was performed.

The service did not have human resource procedures in place. During inspection we spoke with the senior patient advisor, clinical secretary/administrator and a visiting optometrist, however, we could not find personnel files in relation to any of these individuals.

Staff files were not available, and we were unable to confirm the service had obtained, for example, proof of identity, disclosure and barring service certificates, satisfactory evidence of conduct in previous employment.

We were not assured staff had been recruited in full accordance with Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA regulations).

Inspected but not rated

Surgery

Staff told us they were not directly employed, but worked under a self-employed basis and they billed the registered manager/clinician who paid them informally.

Staff told us they had infrequent one-to-one meetings with the registered manager/clinician and no appraisals. These meetings were not documented or recorded. This meant staff had no ongoing or continuous professional development, or wider training opportunities identified to fulfil their management, administrative or secretarial duties.

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.

During inspection staff showed us their latest risk assessment. However, this included only generic risks for the surgery environment and had not been updated for more than two years.

This meant the registered manager/clinician and staff had no knowledge or oversight of the service's main risks, or how to raise, manage, review or update them.

Staff were unable to identify the top risks to the service, and could not identify any. They did say the chair in which the clinician assessed patients was '…mobile, so there was no risk of patient falls'.

The service had no clinical or individual risk assessments for patients or staff.

The service did not monitor or audit patient outcomes post-operatively. This meant the service could not compare their performance or clinical effectiveness to other similar services. Staff told us the service informally discussed outcomes with other clinics, such as their local optician.

The service did not monitor or assess safety performance. For example, they did not use key performance indicators (KPIs), benchmarking or other measures such as referral to treatment (RTT) times. This meant staff, patients and external organisations did not know how well the service performed compared to other similar services.

Staff could not tell us any risks to their clinical environment, despite the room used at the surgery containing large equipment with trailing wires presenting a risk to patients and staff.

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.

We were unable to identify up-to-date and comprehensive information on all patients' care and treatment.

Some policies and procedures were stored on electronic systems in the service registered premises. However, staff were not clear about where to find and how to follow the policies and procedures.

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

Inspected but not rated

Surgery

Engagement

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

Prior to inspection, and in response to a specific request, the service provided a consultation 'Patient Questionnaire' and also a 'Patient Satisfaction Questionnaire - Cataract Post-operative Service'.

These both indicated that they were 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 audits of patient feedback derived from completion of these questionnaires.

We were unable to identify 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The service exposed service users to the risk of harm through a lack of evidence that staff are suitably qualified, competent, skilled and experienced.**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **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 Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	The service was putting service users at risk of harm because they may receive care and treatment inappropriate to their individual needs.

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 Surgical procedures Treatment of disease, disorder or injury	S31 Urgent suspension of a regulated activity The provider must immediately suspend the carrying out of regulated activities from 28 April 2021 until 5 July 2021 at or from the following location: Eagle Eyecare Limited, 194 Totley Brook Road, Sheffield, South Yorkshire, S17 3QY and from satellite locations including the following: 'The Surgery@Wheatbridge', 30 Wheatbridge Road, Chesterfield, Derbyshire, S40 2AB.