Prem House Rotherham

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall summary

Prem House Rotherham is operated by Prem House Limited. The service has eight beds, three operating theatres were on site, but we were told that only one was in use and two clinic rooms.

The hospital building also has another provider and location registered at this address. These are owned by the same individual.

The service provided cosmetic surgery services.

We carried out an unannounced responsive inspection following concerns raised about patient safety. We carried out the inspection on 13 and 14 March 2018 and inspected parts of the safe and well-led domains in surgery.

During our inspection there were no planned surgical procedures due to take place and the hospital was in the process of being sold. The registered manager told us that the hospital was closed for two weeks,from 9 March until 25 March, however they were still providing clinic services, such as consultations and wound checks. The next planned theatre list was for 25 March. We were therefore unable to speak with patients, but we spoke with staff that were in the hospital on the dates we inspected, including the registered manager, and reviewed patient and hospital records.

Services we do not rate

We regulate cosmetic surgery services but we do not currently have a legal duty to rate them when they are provided as a single specialty service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following issues that the service provider needs to improve:

Summary of findings

- Leadership was poor. There was confusion from staff as to who they were employed by and we found that staff were potentially unemployed at the time of our inspection. This was only rectified when we raised it with the registered manager.
- Governance processes were not robust and there was a lack of assurance.
- Medical advisory committee (MAC) and governance meetings had not taken place since July 2017. The registered manager told us this was due to the sale of the hospital.
- Staff records were not kept up to date and information was not held centrally to provide assurance that staff had up to date indemnity insurance, practicing privileges and training. Although this information was provided following the inspection the systems were not in place to ensure availability of this information when required and to provide assurance that the provider was aware of when staff training, etc needed to be reviewed.
- There was a mixture of documentation used which related to two different providers registered with CQC at the same location; this meant that it was not clear about which provider was carrying out the regulated activity and who was accountable for the patients' care.
- There were unsecured old patient records stored in the hospital.
- Staffing in theatres did not comply with national guidance, as there was only one scrub practitioner instead of two.
- The air conditioning system had not had regular verification testing, however following our inspection this was arranged.
- Water safety records showed areas of non compliance with the approved code of practice and guidance on regulations for legionnaires' disease.

We also found the following areas of good practice:

- The environment was visibly clean.
- Audits showed that infection rates were low and had decreased over the last year.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Summary of findings

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Summary of this inspection

Background to Prem House Rotherham

Prem House Rotherham is operated by Prem House Limited. Prem House Rotherham was registered with CQC in December 2016. It is a private hospital in Rotherham, West Yorkshire. The hospital formed part of a wider clinical group that provided cosmetic surgery services for patients in the North West and Yorkshire (advertised through the website of the New Birkdale Clinic). The hospital is registered with the CQC to provide surgery, treatment of disease, disorder or injury and diagnostic and screening procedures.

At the time of the inspection, a new manager, Dr Bhatnagar, had recently been appointed and was registered with the CQC in February 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,three other CQC inspectors, and a specialist advisor with expertise in surgery. The inspection team was overseen by Lorraine Bolam, Head of Hospital Inspection.

Information about Prem House Rotherham

The hospital has one ward, three theatres were on site, but we were told that only one theatre was in use, and clinic rooms. It is registered to provide the following regulated activities:

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

During our inspection, we reviewed 14 sets of patient records and ten staff files. We spoke with the registered manager, a member of nursing staff and administration staff.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently have a legal duty to rate cosmetic surgery services, where these services are provided as an independent healthcare single speciality service.

We found the following issues that the service provider needs to improve:

- Staffing in theatres did not comply with national guidance.
- Resuscitation equipment was not checked regularly.
- The air conditioning system had not had regular verification testing, however following our inspection this was arranged.
- Water safety records from April 2017 showed six out of 13 areas reviewed were non compliant. Staff told us action had been taken to improve the results but they had not been rechecked for compliance.
- Staff could not tell us how reusable laryngoscope blades were cleaned and no standard operating procedure was in place to provide assurance as to how they were monitored and cleaned. We saw a single use laryngoscope blade that was not in any packaging, there was therefore a risk that it was not clean.
- We did not see any escalation process for those patients with an increased national early warning score (NEWS).

However, we also found the following areas of good practice:

- The environment was visibly clean.
- Audit results showed that infection rates were low and had decreased over the last year.

Are services well-led?

We found the following issues that the provider needs to improve:

- Leadership was poor. There was confusion from staff as to who they were employed by and we found that staff were potentially unemployed at the time of our inspection. This was only rectified when we raised it with the registered manager.
- Governance processes were not robust and there was a lack of assurance.
- Medical advisory committee (MAC) and governance meetings had not taken place since July 2017. The registered manager told us this was due to the sale of the hospital.
- Staff records were not kept up to date and information was not held centrally to provide assurance that staff had up to date indemnity insurance, practicing privileges and training.

Summary of this inspection

Although this information was provided following the inspection the systems were not in place to ensure availability of this information when required and to provide assurance that the provider was aware of when staff training, etc needed to be reviewed.

- There was a mixture of documentation used which related to two different providers registered with CQC at the same location; this meant that it was not clear about which provider was carrying out the regulated activity and who was accountable for the patients' care.

Surgery

Safe	
Well-led	

Are surgery services safe?

Mandatory training

- Poor record keeping for staff mandatory training meant that the provider could not be assured whether staff had the correct training to be able to deliver safe care.
- We reviewed 10 staff files, these either contained training records that were out of date or had no evidence of any training records.
- There was no central record of staff training, therefore we were unable to see whether staff had completed the required training during our inspection and the provider was unable to see whether staff training was up to date or when staff training needed to be completed.
- Following our inspection we were provided with staff training certificates for five members of staff, which showed that they were up to date with their mandatory training. However, two members of staff had completed their training on the day of our inspection or in the days following our inspection.

Cleanliness, infection control and hygiene

- We had some concerns around infection control processes. Although the general environment was clean.
- In the theatre that was in use there was some remnants of sticky tape residue on three arm supports and a few defects to the covering. This meant that we could not be assured that the theatre trolley was effectively cleaned.
- We saw that reusable laryngoscope blades were used, there was no packaging or evidence of decontamination status and staff could not tell us how these were cleaned. No standard operating procedure was in place to provide assurance in how these were monitored and cleaned. One member of staff told us they thought single use items were now used.
- On the theatre intubation tray we saw a single use laryngoscope blade and a single use intubation sylet that were not in any packaging. This meant it could not be confirmed when the expiry date was and whether it was clean.
- We requested to review water safety records, to ensure compliance with the approved code of practice and guidance on regulations for legionnaires' disease: the control of legionella bacteria in water systems (L8) and Health Technical Memorandum 04-01: Safe water in healthcare premises. We were supplied with records which showed an independent company had tested the water systems in April 2017; this showed six out of 13 areas reviewed were not compliant. Staff said they had undertaken remedial action to improve the results, however they had not had the system rechecked for compliance and we were not provided with any evidence of action taken.
- It is considered best practice to flush/ run water through all water outlets, these should be flushed at the minimum weekly. However, in areas infrequently used this should be increased as risk assessments indicate, but could be as often as daily. We saw records indicating that flushing was occurring on a weekly basis. Even though some areas of the clinic were not in use and other areas were in occasional use this had not been increased.
- At the time of the inspection we did not receive assurance that the provider had a safe and effective system for managing surgical instruments to minimise the risks to patients to ensure compliance with Health Technical Memorandum 01-01: Management and decontamination of surgical instruments (medical devices) used in acute care Part A: Management and provision and, although dental instruments were not used in the clinic, Health Technical Memorandum 01-05: Decontamination in primary care dental practices was used to ensure compliance with the transport arrangements, when taking instruments off site.
- Following the inspection, we were provided with the service level agreement which the provider had with an NHS Trust for the decontamination of surgical instruments and their procedure for the safe transportation of instruments between sites, however this did not contain full details of how the instruments should be transported between the location at Rotherham and the location at Liverpool.
- During our inspection, we saw a yearly service had been carried out on the air conditioning system in December 2017. However, we were not assured that verification

checks had been completed to comply with Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises. The provider was not able to supply this information, which meant that we could not be assured that the ventilation system was providing clean air and reducing the infection risk.

- Following our inspection, the registered manager booked a healthcare engineering company to visit the location to undertake the ventilation verification and supply certification. Following our inspection, the Head of Hospital Inspections met with the registered manager and was provided with assurance that the required verification checks had been completed and there were no concerns for patient safety.
- Infection rates reported by the provider had decreased since 2016. Infection rates between July 2016 and December 2016 were 4.7% , between January 2017 and July 2017 they were 3.7% and between August 2017 and January 2018 were 2.8%.
- We saw evidence in patient records of MRSA screening.
- All areas we visited were visibly clean. We saw 'I am clean' stickers on equipment, however, the sticker on the spare anaesthetic machine was dated 9 July 2017. Sharps bins were correctly labelled and appropriate waste bins were used.

Environment and equipment

- Clinic rooms were equipped with appropriate equipment and furniture. We saw service labels on equipment to indicate that electrical testing had taken place, these were all in date.
- Resuscitation equipment was available. We checked the contents of the resuscitation trolley and found all items to be in date. The resuscitation checklist stated that the trolley should be checked weekly but records indicated that it had only been checked on 23 November 2017, 16 December 2017, 8 January 2018, 20 January 2018 and 10 March 2018.
- Oxygen cylinders were stored correctly and were in date.
- We reviewed the anaesthetic machine log book and the operation register and saw that on nine out of 21 days that there were operations taking place, the machine had not been checked. Pre use checks should be carried out to ensure the correct functioning of anaesthetic equipment and is important for patient safety.

Assessing and responding to patient risk

- Staff carried out risk assessments on admission, including a manual handling risk assessment, deep vein thrombosis risk assessment, pressure area risk assessment and a nutrition assessment.
- Staff used the World Health Organisation (WHO) safety checklist. During the inspection, we were not able to observe any surgery taking place so received limited assurance that the five steps to safer surgery including the World Health organisation (WHO) surgical safety checklist was being used effectively.
- We reviewed patient records including the WHO checklist; in all the records the WHO checklist was complete. We were not able to see documentation on the team brief element of the five steps to safer surgery procedures.
- During this inspection, staff told us they used the national early warning score (NEWS) tool; they used a paper based system to record the early warning score. It was not clear how staff escalated any patients of concern to medical staff, or which criteria they used to do this. In the records we reviewed, staff had calculated the NEWS score based on the patients observations, however we did not see acceptable parameters set or evidence of any escalation procedures if a patient's observations were above acceptable parameters.
- In eight records we reviewed it had been documented that all eight patients had been offered a pregnancy test but declined, in all cases the surgery continued but it was unclear if there had been a discussion about the risks if pregnant.
- We saw evidence that before patients were discharged home following surgery they were reviewed by the consultant and seen by the registered medical officer (RMO).
- It is recommended in the Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery (April 2016) that patients undergoing cosmetic surgery should be given a time for reflection and ensure that consent is obtained by a two stage process, with at least two weeks between each process. If this is not possible good reasons should be recorded in patient's notes. In every set of records we reviewed the patient had signed an initial consent form on the day of consultation. They then signed a further consent form on the day of surgery, which was at least two weeks later. This showed that they were following good practice.
- The RCS Standards also recommend that surgeons make attempts to identify psychologically vulnerable

patients and refer these patients to mental health experts pre surgery. We saw evidence of two patients having pre-existing mental health conditions including depression and anxiety but there was no documentation in the notes showing that these patients received further counselling or assessment; some of these patients were receiving medication for the condition at the time of the consultation. This was not good practice.

Nursing and support staffing

- When in use, the ward area was staffed by one registered nurse and two healthcare assistants. We saw evidence of this in the patient records.
- Staffing in theatres was not in line with national recommendations as set out in the Association for Perioperative Practice guidance (2014), as there was only one scrub practitioner; the guidance recommends two scrub practitioners.
- Staff told us that there was not a surgical first assistant (SFA) and that this was a dual role carried out by the scrub practitioner. This was not in line with Perioperative Care Collaborative guidance (2012) and there was no policy in place for this. The guidance states that 'registered practitioners should not undertake the role of SFA until the relevant organisation has a policy in place to support this clinical practice. The individual concerned must have this role specified in their job description and contract of employment. We did not see this specified in any staff files.

Medical staffing

- Surgery was consultant led and delivered. Surgeons saw the patient before discharge.
- The registered medical officer (RMO) was on site for theatre lists and provided medical cover until the point of discharge. We saw in records that we reviewed that the RMO saw the patients before discharge.

Records

- Records were generally of a good standard, although there were some issues with the paperwork used and the documentation of consultations.
- We reviewed 14 sets of records and in every record we saw a mixture of paperwork being used. Some referred to Prem House Rotherham and some referred to another provider registered with CQC at the same location, owned by the same individual. Staff told us that both sets of paperwork had always been used. This meant that it was not clear about which provider was carrying out the regulated activity on each patient and who was accountable to the patients' for their care.
- The clinical records we reviewed were of a good standard. They contained appropriate pre operative assessments, anaesthetic records, operation records, prescription charts, patient observations and discharge paperwork. In three sets of notes we had difficulty reading the surgical plan due to some crossing out.
- Details were kept of implants used, with a label placed in the patients' records and a record kept in the breast implant record book. We checked the breast implant record book and this had been completed correctly for all patients. This enabled implants to be traced if any problems occurred.
- During the inspection, it was clear that healthcare assistants were documenting consultations, however, due to the level of documentation it was unclear whether the HCA provided individual discussion or just recorded discussions between patient and doctor. If they did provide individual discussion, we did not see evidence of role specific training to allow them to safely carry out this level of intervention.
- If consultants were not documenting their own discussions with patients there is a risk that all relevant information may not be recorded. General Medical Council (GMC) guidance states that doctors should record their work clearly, accurately and legibly.

Are surgery services well-led?

Leadership

- There was a registered manager in place for Prem House Rotherham, they had been registered since February 2018. However, when we first arrived at the location there was some confusion from staff as to who the provider, owner and registered manager was, as the hospital was in the process of being sold.
- We saw paperwork, including staff sign in sheets, that related to another provider not registered at this location. Staff told us this was to be the name of the new clinic once the sale of the property had completed. This meant that there was no clarity for patients as to who was accountable for their care.

- There appeared to be a lack of engagement with staff, as staff we spoke to were unaware that they were still working for the registered location.
- At the time of our inspection, the employment status of staff was unclear as they had been given their P45s due to the impending sale. We raised this with the registered manager and staff were then re-employed by the provider. This ensured that they had professional indemnity insurance should an incident occur.

Governance, risk management and quality measurement

- During our inspection we were not assured that there were effective governance arrangements in place. There was no oversight of risks or audits, no way of monitoring new procedures or compliance with national guidance.
- The registered manager told us that some of the documentation we requested to see had been moved off site as they prepared for the finalisation of the hospital sale.
- There was no record of any medical advisory committee meetings (MAC) or governance meetings taking place since July 2017. When we spoke with the registered manager he told us that there had been no meetings as they were preparing for the sale of the hospital and they had not been quorate for the meetings. This meant that there was no oversight of quality and risk.
- The registered manager told us that the hospital had closed and refurbishments were being completed. However, patients were still been seen for wound checks and consultations. The hospital was due to reopen on 25 March 2018 for surgical procedures. Staff we spoke with were not aware that the hospital had closed. This meant that staff were not kept up to date of changes within the service.
- We were not assured that there were robust processes in place to to keep staff records up to date. There was no central recording system for mandatory training. Evidence of training and indemnity insurance had expired in some staff files. However, we were provided with this evidence following our inspection.
- The registered manager was unaware that there was a requirement for the air conditioning system to be validated every year to ensure that the ventilation stsytem was fit for purpose and met the requirements of statutory regulation, standards and published guidance in healthcare.
- During our inspection we saw paperwork relating to two different providers, it was therefore difficult to establish which provider the patient was been seen by. In the patient records it stated that their operation would take place at a hospital registered with the CQC, either at the Prem House Rotherham location or another CQC registered hospital. This means that at the time of consultation and booking the patient could not be sure of where their surgery would take place or by which regulated provider.
- Old records were not stored securely. We saw old patient records, dating back to the year 2000 and before, staff records from between 2002 and 2007 and theatre recovery registers from 2006, stored unsecured in parts of the building.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider MUST ensure that appropriate governance systems and processes are established and operated effectively to ensure assess, monitor, mitigate, evaluate and improve the quality and safety of services it provides.
- The provider MUST ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed.
- The provider MUST ensure that records are stored securely.
- The provider MUST ensure that there are processes in place for the deteriorating patient.
- The provider MUST ensure that staff have completed their required training and there are processes in place to provide assurance that staff are appropriately trained.

Action the provider SHOULD take to improve

- The provider SHOULD ensure that resuscitation equipment is checked regularly.
- The provider SHOULD ensure that regular verification checks of the air conditioning continue.
- The provider SHOULD ensure that there is a comprehensive policy in place for the transport of instruments between locations that complies with the Health Technical Memorandums for the management and decontamination of surgical instruments.
- The provider SHOULD ensure that there is clear documentation in patient records with regards to pregnancy to prevent the patient who does not know they are pregnant from having surgery.
- The provider SHOULD ensure there is documentation in the patient records to indicate whether the option for counselling has been discussed with those patients with pre existing mental health conditions and what the outcome was.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have any processes for the escalation of a deteriorating patient. Regulation 12(2)(b)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not established systems and processes to ensure they assessed and monitored the service. Regulation 17(1) The provider was keeping old patient records unsecured. Regulation 17(2)(c) The provider did not keep up to date records relating to persons employed in the carrying on of the regulated activity. Regulation 17(2)(d)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed. Regulation 18(1)