The Belvedere Private Hospital

Quality Report

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Date of inspection visit: 1 November 2016
Date of publication: 07/04/2017

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Belvedere Private Hospital is operated by Pemberdene Laser and Cosmetic Surgery Clinic Ltd.

The hospital has eight in-patient beds, and the facilities include one operating theatre, anaesthetic room and a recovery room. There is one consultation room with two new consulting rooms being built at present.

The Belvedere Private Hospital provides cosmetic surgery, mainly breast augmentation, but also abdominoplasty, blepharoplasty and liposuction. We inspected surgery services only.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 1 November 2016, along with an unannounced visit to the hospital on 9 November 2016.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We do not currently have a legal duty to rate cosmetic surgery services or the regulated activities they provide but we highlight good practice and issues that service providers need to improve.

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

- Incidents were not discussed at the medical advisory committee or governance meetings. Further, consultants were required to attend at least two medical advisory committee and governance meetings per year as per hospital policy; we did not see evidence of adherence to this policy.
- The processes to monitor risks to patients and staff were not fully implemented. A patient with history of depression had not undergone psychological assessment as per the hospital's guidance. Female patients did not routinely receive a pregnancy test on the morning of their surgery. Further, during the post-operative recovery period patients were not assessed and monitored in accordance with a suitable assessment tool.
- With regard to infection prevention and control, a bed pan was stored in a patient bathroom on the floor. There was out of date antibacterial skin cleanser in a patient bedroom.
- Equipment did not always show evidence of having been subjected to safety checks. there were two pieces of electrical equipment in theatre for which safety testing had expired in April 2016, fire extinguishers in the ward area were not secured in line with Regulation Reform (Fire Safety) order 2005.
- There were no window restrictors on the windows in patient's rooms on the 1st floor.
- The safeguarding children's policy did not reflect the most up to date guidance. Further, the level of safeguarding training required of staff was not stated.
- No member of employed staff had undertaken immediate life support (ILS) training.
- The registered manager did not have access to clinical supervision or peer review.
- Learning from complaints was not clearly demonstrated.

However, we found the following areas of good practice:

- The patient guides on specific surgeries, provided a great deal of useful information for patients about what to expect before, during and after their surgical procedures.

Summary of findings

- The theatre and ward areas were visibly clean.
- All patient records we reviewed demonstrated communication with the patient's GP by means of a standard letter pre and post-operatively

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. Details are at the end of the report.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to The Belvedere Private Hospital

Belvedere Private Hospital is operated by Pemberdene Laser and Cosmetic Surgery Clinic Ltd.

The hospital opened in 1985. It is a private hospital in South East London. The hospital primarily serves the communities of the London and North Kent areas and also accepts patient referrals from the whole country. The inspection was an announced inspection, which took place on 1 November 2016, with an unannounced inspection on 9 November 2016.

The hospital has had a registered manager in post since 20 May 2015.

The hospital also offers cosmetic procedures such as dermal fillers. We did not inspect these services, as they do not come under the requirements of current regulations.

Our inspection team

The team that inspected the service comprised of a CQC inspection manager Margaret McGlynn, a CQC lead inspector, one other CQC inspector and three specialist advisors with expertise in cosmetic surgery.

Why we carried out this inspection

We inspected the hospital as part of our independent hospital inspection programme.

How we carried out this inspection

To understand the patients' experiences of care, we always ask the following five questions of every service and provider:• Is it safe?• Is it effective?• Is it caring?• Is it responsive to people's needs?• Is it well-led? We analysed information that we hold on the service prior to our inspection. During the inspection, we visited the ward and the theatre. We spoke with five staff including; the director, registered nurses and medical staff. We spoke with two patients and reviewed 10 sets of patient treatment and care records.

There were no special reviews or investigations of the hospital on going by the CQC at any time during the 12 months before this inspection. The hospital has been inspected four times; the most recent inspection took place in February 2016.

Information about The Belvedere Private Hospital

The hospital had one ward, one theatre, a recovery area and anaesthetic room and was registered to provide the following regulated activity:

Surgical procedures.

Summary of this inspection

Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016, there were 407 inpatient and day case episodes of care recorded at the hospital; of these 100% were privately funded.

  In total five surgeons and one anaesthetist had worked at the hospital under practising privileges. However at the time of our inspection there were three surgeons with practicing privileges at the hospital. Three regular resident medical officers (RMO) worked on an as required rota. Two registered nurses were employed as full time staff, and the hospital had its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety :

- Three clinical incidents
- No serious injuries

There were No incidences of hospital acquired Meticillin-resistant Staphylococcus Aureus (MRSA), Meticillin-sensitive Staphylococcus Aureus (MSSA), Clostridium Difficile (c.diff) or E-Coli in the year July 2015 to June 2016. There were 12 complaints reported in the same time frame.

Summary of this inspection

Services provided at the hospital under service level agreement:

- Clinical and non-clinical waste removal
- Maintenance of medical equipment

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 found there were systems to report and investigate safety incidents and to learn from these. Patient records were properly completed; however processes to monitor risk to patients and staff were not fully implemented. Incidents were not discussed at the Medical Advisory Committee. Theatre staff completed the World Health Organisation (WHO) surgical checklist during procedures and they had enough properly maintained equipment. However, nursing staff were not using a recognised tool to monitor and assess the condition of patients following their surgical procedure. Female patients did not have pregnancy testing prior to surgery this was contrary to the hospitals own policy. The hospital should develop a more robust procedure for checking dates of medicines and medical gases to ensure out of date stock is replaced immediately. Safeguarding children's policy was not up to date with recommended guidance, and the levels of safeguarding training staff were required to have completed was not clearly stated.

Are services effective?

Care was planned and delivered in accordance with current guidance, best practice and legislation by suitably skilled and competent staff. There was a programme of audit, which was used to assess the effectiveness of services and to maintain standards; however audits were not carried out as frequently as they should have been according to the hospital's own policies. Patients' pain was well controlled, and their nutritional needs were met.

Are services caring?

Patients were treated with kindness and respect. Patients gave positive feedback and said they were treated well by staff, and with compassion and dignity. Costs were discussed and agreed at initial consultation.

Are services responsive?

Services were planned to meet the needs and choices of patients, and the arrangements for treatment were prompt. There were arrangements to ensure the individual needs of patients were considered, assessed and met. Complaints were appropriately acknowledged, investigated and responded to in a timely way; however we did not see any discussion about or learning from complaints in the staff meetings.

Are services well-led?

The service had an established manager, who had an effective working relationship with their staff. Staff understood what the

Summary of this inspection

values and purpose of the service were, and what was expected of them. They were committed to meet the requirements of their patients. There was no written vision and strategy for the service; however plans to expand the service in the future were discussed. The governance arrangements did not provided assurance of systematic monitoring of the quality of services. The risk register was not robust and did not reflect the risks to the organisation fully.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

We did not rate safe.

Incidents

- There were no never events during the reporting period of July 2015 to June 2016. (Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers).
- There were two incidents, which related to missing sutures, in both cases the sutures were found on the floor and no further actions were required.
- There were three other incidents reported during the same reporting period. These related to one needle stick injury, an incorrect documentation of breast implant and one return to theatre. All incidents were investigated by the registered manager and feedback provided to individual staff. However, we did not see evidence of incidents being discussed at the Medical Advisory Committee (MAC) or governance meetings when reviewing the minutes submitted by the provider.

Duty of Candour.

- From November 2014, registered persons were required to comply with the duty of candour, Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency, and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.
- The staff we spoke with had a good understanding of 'duty of candour', although there had not been any incidents requiring its application.

Cleanliness, infection control and hygiene

- There was a dedicated member of staff responsible for cleaning. This person had received the appropriate training and was therefore able to follow best practice with respect to minimising cross-contamination.
- The patient, ward, reception and theatre areas were visibly clean during our announced visit and the equipment we looked at had labels on them to indicate when they were last cleaned.
- Disposable curtains were used in the two bedded patient rooms and staff told us these were changed every six months or sooner if soiled.
- The deputy manager informed us sharps bins were regularly inspected and changed monthly.
- There was no sluice room on the ward but staff could access the sluice situated next to theatre. Staff we spoke with told us this was rarely required as patients were mobile and able to access the en-suite toilet. However, we found a bedpan stored on the floor underneath the sink in one of the patient bathrooms rather than in the sluice room. This was poor infection prevention and control practice (IPC).
- The clinic had commissioned the services of an external company to provide IPC services such as audits, staff training and improve local implementation of infection

control policies. An annual IPC report had been produced and was available for staff and the public to view. We noted this contained a summary of all IPC activities, including audit and policy reviews.

- We observed the last IPC meeting had been jointly attended by staff from the clinic and the external company, which took place in February 2016.Infection Control & Governance Meeting minutes were recorded and shared with staff.
- The IPC audit which took place in June 2015 highlighted a list of actions required. A re-audit was undertaken in June 2016 and the hospital was deemed to be 100% compliant.
- There were no reported surgical site infections in the reporting period July 2015 to June 2016. The nurse saw the patient seven days post operatively; if they were concerned about the wound, they did not swab the wound but advised the patient to see their GP. This meant the consultant may not have been aware of potential wound infection matters and therefore not be reporting them.
- There was easy access to personal protective equipment (PPE) such aprons and gloves in all areas we inspected.
- The consultation room, where patients were seen for wound checks post-operatively, had carpeted flooring; this did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment. Although this risk had been highlighted during a previous inspection, it was not included on the risk register. However, the clinic was in the process of building additional consultation rooms and the Nominated Individual (NI) and Registered Manager (RM) informed us the current consultation room would not be in use once the building works were completed.
- We found the antibacterial skin cleanser in one of the patient room had expired in 2014. This meant staff using this product may not be appropriately decontaminating their hands.
- Decontamination services for surgical instruments were provided under contract by a local NHS trust. The standards of this service were monitored by the hospital.

Environment and equipment

- The ward, theatre and recovery areas were suitably arranged to enable the delivery of services.
- The service had a contract with an external company for maintenance and servicing of all equipment. The equipment in use on the ward had a sticker indicating it had been serviced in the past six months. However we observed the anaesthetic machine and patient monitor in theatres had stickers, indicating the safety service had expired in April 2016.
- A member of theatre staff completed a checklist for anaesthetic equipment on each day the clinic carried out surgery and we saw evidence of these checks.
- The electrical equipment we looked at had safety testing stickers except for two fans in patient rooms. The clinic informed us that both fans had just recently been purchased and when we revisited on our unannounced inspection the fans had been tested.
- Fire extinguishers on the ward were not secured to the wall or stored on appropriate fire extinguisher stands to ensure the top handle was at the required height, in line with Regulatory Reform (Fire Safety) Order 2005.
- Resuscitation trolleys were available in theatre and on the ward. We saw evidence the contents of the trolleys was checked each day the clinic was operational.
- All patient rooms were situated on the first floor but the windows did not have restrictors, which could pose a health and safety risk to patients and visitors. Some of the windows in patient rooms were in a poor state of repair.

Medicines

- Controlled drugs (CD) were stored in a separate locked cupboard and checked twice daily. There was a clear process for administration of controlled drugs, which staff were aware of and followed. We reviewed the contents of the CD cupboard against the CD book and did not find any discrepancy.
- Any drugs required by patients post-operatively were prescribed under private prescription.
- Oxygen cylinders were available at each bed space in patient rooms and were appropriately stored in a wall mounted stand.

Surgery

- We observed emergency drugs on the resuscitation trolleys; both on the ward and in theatre expired in 31 October 2016 and had been not replaced during our announced inspection on the 1 November 2016. Staff explained the drugs had been ordered and were due to be delivered the next day. We were assured that the delay was acceptable as the clinic was not operating on the day of our announced inspection.
- We saw a cylinder of nitrous oxide (a gas used for anaesthesia and pain relief), which had expired in July 2014, in the operating theatre. We highlighted this to the RM who took immediate actions to remove and replace this cylinder.
- We reviewed 10 medication charts and observed in two of these charts; patient allergies were not recorded, despite one of the patient having a medication allergy recorded at their pre-assessment consultation. Lack of recording information such as this may put the patient at risk of having inappropriate medicines prescribed.

Records

- Patient records were stored on site and contained information for the whole patient journey, from the first consultation to their follow up reviews post-operatively.
- We looked at 10 sets of records during our inspection. We saw patients underwent a pre-assessment consultation with the nurse, which included risk assessment and checks against the admission and acceptance criteria. Post-operative care plans were clear and sufficiently detailed. Post-operative progress notes were evident from the nursing staff but there was no post-operative documentation from the surgeon, such as a post-surgery review. The resident medical officer (RMO) completed and signed the discharge documentation and a copy was sent to the patients GP.
- Staff kept a record of all breast implants in the patient notes and in the hospital's breast implant register. Patients also received a card with details of the size and make of the implant. The clinic was in the process of establishing a system to contribute data to the recently established National Breast Implant Register.
- Patients were all screened pre-operatively for meticillin-resistant Staphylococcus Aureus (MRSA) and the results filed in the records. Venous thromboembolism (VTE) risk assessments were undertaken pre-operatively and we saw evidence of this within the notes we reviewed.

Safeguarding

- There had not been any safeguarding matters reported to the commission during the year up to our inspection visit.
- The service had a safeguarding children in the adult setting policy, which included the local authority safeguarding team contact number. The policy was limited in that it did not reflect the latest guidance as outlined in the intercollegiate document: Safeguarding children and young people: roles and competences for health care staff, (2014). There was no indication as to the level of safeguarding children's training, or the frequency of training. Guidance recommends level 2, as a minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers. Further, the policy did not mention such matters as 'PREVENT', which is the government's response to the terrorist threat in the UK.
- The separate adult safeguarding policy had been updated in June 2016, and indicated adult safeguarding training was part of induction and staff were to attend annual adult safeguarding training.
- All staff had received training on safeguarding adults and were able to explain what actions they would take if they had a safeguarding concern.
- The RM and the deputy nurse manager were safeguarding leads, and were trained to level three and two respectively.

Mandatory training

- All clinical and domestic staff had completed their mandatory safety training within the last two years. Subjects they were expected to complete included; first aid, IPC, fire safety and manual handling.
- Two members of the clinical staff, the RM and deputy manager were certified in basic life support (BLS) and were always available when patients were in the hospital.
- RMO and anaesthetic had advanced life support (ALS).

Surgery

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- There was an admissions acceptance criteria in order to ensure only those individuals who were suitable to receive treatment at the service were accepted.
- The deputy manager carried out a pre-operative assessment and although most patients were low risk, the deputy manager was able to arrange for a pre-operative anaesthetic review if this was required.
- Staff contacted the patient's GP to determine if they held any information that would make the proposed surgery unsuitable. They asked patients to sign a disclaimer if they did not wish their GP to be contacted. We saw evidence of GP returned completed forms in the records we reviewed.
- We did not see evidence that patients underwent a psychological assessment prior to having surgery. Staff told us they would request information in cases where patient were already accessing psychological or mental health services. We saw evidence in the notes we reviewed, that some patients had declared a history of depression but staff had not taken any action to initiate a psychological assessment.
- Nursing staff regularly reviewed patients post operatively and observations were recorded; however, they were not using an early warning score to determine when patient needed further escalation which was against the National Institute for Health and Care Excellence (NICE) guidance CG50. Staff told us the RMO was present on the ward and they would always escalate to the RMO if they were concerned.
- All patients were screened for venous thromboembolism (VTE) pre-operatively. Patients were prescribed prophylaxis treatment as indicated.
- Staff followed the 'five steps to safer surgery' before, during and after surgery to enhance the safety of patients. A recent audit carried out by the RM showed 100% compliance with the surgical safety checks. However in the records we reviewed, we saw the debrief was not always documented.
- At the unannounced inspection, we followed one patient from the ward to theatre. We observed the use of the five steps for safer surgery checklist.The five steps are pre-list briefing, the three stages of the World Health Organisation (WHO) Surgical Safety Checklist (sign-in, time-out, sign-out) and post-list debriefing. We saw there was a sign in and a time out. We reviewed another patient's notes that showed there had been a full sign in, time out and sign out. Staff told us they had had a briefing earlier that morning. All staff were present for the sign in and sign out, we observed in theatre.
- Staff told us they would transfer patients to the local NHS hospital via an emergency ambulance if they deteriorated whilst in the care of the hospital. The NI and RM informed us theyhad negotiated a service level agreement (SLA) for transfer of patients to a nearby hospital. We saw a copy of the draft SLA, which they wereawaiting this to be signed by the NHS trust.
- The RMO was required to have Intermediate Life Support (ILS) training but nursing staff received only basic life support training. In the event of a cardiac arrest, the anaesthetist, who possessed Advanced Life Support training, would need to come out of theatre. Staff told us this had never happened at the clinic. However, if the anaesthetist would be called out of theatre such a situation would leave the patient on the operating table at risk.
- During our announced visit, we observed the patient call bell had been tied up which meant patients were not able to reach up (such as following breast surgery) or those requiring assistance while sitting on the toilet would not be able to reach the call bell. Staff explained the call bell was tied up to allow for cleaning as the rooms were not in use on that day. The situation was rectified immediately when we pointed it out.
- Although the majority of patients undergoing surgery were young females, we noted that none of the patients whose records we reviewed had a pregnancy test carried out on the morning of their surgery. The National Institute for Health and Care Excellence (NICE) NG45 routine preoperative tests for elective surgery guidance, states that a service should "Carry out a pregnancy test with the woman's consent if there is any doubt about whether she could be pregnant". The hospital has a pre-operative pregnancy test policy which stated "routine pregnancy tests carried out before a planned operation/ procedure for all female patients from the age of 18 to 55 years".

Surgery

- The hospital did not provide high dependency, intensive or overnight care. In an emergency situation the standard 999 system was used to facilitate the transfer of the patient to an NHS hospital.

Nursing and support staffing

- The provider informed us the staffing of theatres was based on guidance outlined in the 'Association for Perioperative Practice (AfPP) '. Theatre was staffed with two scrub practitioners, one anaesthetic practitioner, one recovery practitioner, and one porter. The matron was available to co-ordinate activities.
- Acuity for the ward was said to be taken from RCN guidance, and depended on the level of care provided. Staffing was said to consist of two trained registered nurses, with usual numbers of admissions ranging from five to eight.
- If needed, night staff would include a registered nurse and a registered medical officer (RMO). In this situation patients were said to be discharged at 8am the next morning by the RMO.
- We found the RM and deputy manager were the only nurses employed by the clinic. All other nursing and support staff were either bank or agency. The nominated individual (NI) and RM informed us they were using more bank staff rather than agency staff in order to increase stability and continuity at the hospital.
- The patient co-ordinator, receptionist and administrative staff were all employed on the bank.
- We saw evidence all bank or agency staff underwent an induction and orientation on their first day.
- The theatre staffing levels were in line with those recommended by the Academy of Medical Royal Colleges' 'safe sedation practice for healthcare procedures October 2013.
- On the days where the clinic carried out surgery, staffing numbers were generally two nurses on the ward and three theatre practitioners and a recovery nurse. These staffing levels agreed by the RM were appropriate for the type of procedures undertaken. When we returned to the hospital for the unannounced inspection we observed the level of staffing listed above on the ward and in the theatre. The three nurses that we spoke with were bank staff and had worked regularly at the hospital for a period of time up to two years. They were very familiar with the hospital and its procedures.
- The RM worked in theatre when surgery was taking place to maintain her competencies.

Medical staffing

- There were three surgeons with practising privileges at the time of our inspection. The anaesthetists and RMO were provided through an agency, although there was one anaesthetist working on the bank. The RM told us they used regular agency staff.
- In cases where an overnight stay was required, the RM booked the RMO for a 24 hour shift.
- Most surgery was carried out as day cases, so there were no arrangements in place for emergency cover for surgeons.
- The RM informed us they had the contact details of all the surgeons and were able to contact them for advice anytime. Surgeons at the clinic would review patients for each other, when an urgent review was required for a patient post operatively and the patient's surgeon was not available for review.
- Surgeons were contactable 24 hours a day by telephone and were required as part of their contract be able to return to the hospital within 30 minutes should an emergency require them.

Emergency awareness and training

- Procedures for emergency evacuation in the event of a fire were set out in the hospital's policy for fire risk management.
- There was a back-up generator to power the lights or equipment in the event of a loss of electrical supply.

Are surgery services effective?

We did not rate effective

Evidence-based care and treatment

- Whilst there was access to policies and procedures, staff did not always adhere to these. Further, professional guidance was not followed with regard to the management of the deteriorating patient.

- There was a hospital program of audits undertaken, which included audits of consent forms, treatment register, IPC and clinical records. IPC Audit results were at 100% in July 2016
- The hospital manager had a good knowledge of the results of the clinical audits, which enabled a prompt response to any negative outcomes.

Pain relief

- Post-operative pain relief was prescribed by the anaesthetist and included regular and as required painkillers. Nursing staff told us they would get the RMO to review patients whose pain was not controlled.
- Pain was assessed regularly using a patient reported scoring system of 0-3, where 0 was no pain and 3 was severe pain. We saw evidence of pain scores in all the records we reviewed. One patient we spoke with told us that their pain had been managed effectively.
- We did not see any evidence of auditing of staff compliance with pain assessments, and were unsure if they were assessing this element of practice.

Nutrition and hydration

- Pre-assessment and ward nurses advised patients of fasting times before surgery and we observed this was in line with the Royal College of Anaesthetists (RCOA) guidelines.
- Patients were offered refreshments and sandwiches when they could tolerate this post-operatively.
- Patients were asked about their food and water intake prior to surgery by the nurse and were told about the amount of time they would have to fast before surgery during their pre assessment appointment.

Patient outcomes

- The number of surgical procedures carried out in the reporting period was 407.
- Patients were asked to complete a questionnaire to assess their overall experience, but there were no specific questions relating to their satisfaction with the outcome of their procedure.
- The clinic was in the process of developing systems to contribute data to the Private Healthcare Information Network (PHIN), in accordance with legal requirements regulated by the Competition Markets Authority.
- The clinic was currently not collecting Patient Reported Outcome Measures (PROMs) for cosmetic surgery as recommended by the Royal College of Surgeons.
- During the reporting period of July 2015 to June 2016, there had been one case of unplanned return to theatre but no cases of unplanned transfers.
- The hospital did not contribute to cosmetic services databases.

Competent staff

- The deputy manager and RM had both received an appraisal in the last year. The RM carried out the deputy's appraisal and provided clinical supervision and support.
- The NI appraised the RM but the RM did not have access to clinical supervision or peer support, as she was the only theatre nurse employed by the clinic. There was no agreement in place for her to access that support from external sources.
- The RM told us consultants were expected to have an up to date appraisal as part of their practising privileges. When we checked consultant files we found all of the current consultants had an appraisal and were listed on the General Medical Council's specialist register.

Multidisciplinary working

- The staff we spoke with all reported good working relationships with colleagues and consultants.

Access to information

- Staff had access to patient information from the records stored on site.
- MRSA screening results were available to staff electronically. Staff then printed the result to include in the patient records.
- All patient records we reviewed demonstrated communication with the patient's GP by means of a standard letter pre and post-operatively. The standard letter sent to the patient's GP on discharge provided information on the surgery performed and the prescribed medicines on discharge.
- Staff had access to electronic and paper copies of hospital policies and guidelines on the ward and in theatres.

- Routine blood tests were not carried out prior to surgery unless a consultant had concern and specifically requested them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients received verbal and written information relating to their procedures. For example, there was a procedure information sheet for all procedures offered such as rhinoplasty and breast implant surgery. Consent forms for procedures contained information about the risks and benefits.
- We saw consent sheets were signed by the surgeon and the patient on the day of the operation.
- Although the RM told us the clinic adhered to the recommended two weeks cooling off period prior to cosmetic surgery, we saw evidence in the records we reviewed this was not always adhered to. We saw three patients, in the 10 records we looked at, who had their surgery less than 14 days from their initial consultation with the surgeon performing the procedure. This may not allow patients the time to fully consider the risks of the surgery they were about to undertake.
- The staff we spoke with could confidently tell us their understanding of the mental capacity act (MCA) and deprivation of liberty safeguards.

Are surgery services caring?

We did not rate caring

Compassionate care

- Staff at this hospital treated patients with care and compassion and provided patient-focused care that met individual needs. Patients we spoke with and those who responded to the hospital were very positive about their treatment.
- Patient feedback was positive regarding the standard of care they received. We spoke with two patients who told us the care was excellent. Patients told us staff had been extremely helpful and they were encouraged to contact the clinic if they had any concerns.
- We observed interactions between staff and a patient prior to, during and following a surgical procedure. Staff were very caring and kind in their administrations, and demonstrated a calmness and compassion. Any discussions were open and informative, with checks on understanding and agreement.

Understanding and involvement of patients and those close to them

- The patient we spoke with said they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- The patient co-ordinators gave support on non-clinical matters such as appointments and costs. Where patients' required clinical advice, either a consultation or a telephone conversation was arranged.
- Patients were offered the opportunity to have a friend or relative present during consultations and examinations. There were signs in the reception area that indicated to patients that a chaperone could be provided if required.
- Patients we spoke with told us they felt involved in the decision making process regarding their procedures, because everything was explained clearly and they had the opportunity to ask whatever questions they wanted to.
- All patients were asked to complete a patient satisfaction questionnaire prior to discharge and again at their first follow up appointment. The questionnaires we viewed were fully completed and patients were satisfied with the service they received.
- Costs of treatment were discussed and agreed with patients at their initial consultation.

Emotional support

- Patients were given a number they could ring 24 hours a day following their surgery. The RM or the deputy manager was available to provide advice and reassurance when patient called.
- The RM told us when a patient was unsure of whether to proceed or not, they could offer the patient a second opinion by arranging a consultation with a different surgeon.
- Psychological testing and support was not routinely provided.

Surgery

Are surgery services responsive?

We did not rate responsive

Service planning and delivery to meet the needs of local people

- The hospital provided cosmetic procedures to adults over the age of 18 years.
- There was a patient co-ordinator based at the hospital, who responded to enquiries made via the hospital's website or by patients who called the hospital directly.
- As the hospital provided private elective surgery, admissions were planned in advance at times to suit the patients. In general, procedures carried out at the hospital did not involve an overnight stay, although this could be arranged if necessary.
- The service planned their operating schedule according to patient bookings and surgeon's availability. The RM told us they usually carried out surgery two to three days every fortnight.
- The RM planned staffing in advance and ensured enough staff was available to meet the needs of patients, including those requiring an overnight stay.
- The hospital had gained planning permission to build two additional theatres and 18 more beds; however the plan was not to commence the work for a few years.

Access and flow

- There were 407 inpatient and day case episodes of care recorded at the hospital in the reporting period July 2015 to June 2016.
- There had been 18 procedures cancelled for non-clinical reasons in the reporting period from July 2015 to June 2016. Of those 94% were offered another date for their operation within 28 days of the cancellation.
- The ward had capacity for eight patients and staff we spoke with told us the ward was never filled to capacity.
- Patients were seen within two weeks of request for a consultation and in the majority of cases operations were planned for two weeks following the consultation. Consultations were offered at times convenient to the patient.
- There had been one unplanned return to theatre in the reporting period. Staff explained the decision to return to theatre was made while the whole team was still present after the surgery and there were no delays. There were no unplanned returns to theatre out of hours
- Patients were discharged home with post-op care instructions, a discharge summary; any prescribed pain medication and pre-booked appointments for follow-up care.

Meeting people's individual needs

- Each surgical patient was provided with a patient guide booklet, which set out the stages of the patient's journey with the hospital. It explained what is required from the patient and what would be offered by the hospital.
- The patient's discharge plan included advice specific to the procedure that had been undertaken as well as information relating to any pain relief or antibiotics that patients were given to take home.
- Due the nature of the procedures undertaken at the hospital, the hospital did not accept any patients who were living with dementia or learning disability.
- Staff gave patients clear instructions about managing their surgical wounds and any follow up appointments that were required.
- Patients were provided with a document which detailed the surgery they were having, risks, complications and limitations of that surgery, information about the hospital and the staff and how to make a complaint.
- Translation services could be provided by a telephone translation service. A telephone number was visible in the reception area.
- There was no training for staff on cultural needs.

Learning from complaints and concerns

- The provider had received 12 complaints during the reporting period. The rate of complaint (per 100 inpatient and day case attendances) was higher than the rate of other independent acute hospitals we hold this type of data for.
- Staff told us in cases when patients were unhappy with aspects of their care, they would escalate to the RM who would aim to resolve any issues verbally.

- We saw evidence the RM and NI investigated all complaints and patients were sent acknowledgement letters, response to their complaints, and at times were invited to attend a meeting to further discuss their complaint. A written complaints acknowledgement was sent in five working days and a formal response within 28 working days.
- We did not see any discussion or learning from complaints in the staff meeting minutes we reviewed.

Are surgery services well-led?

We did not rate well-led

Vision and strategy for this this core service

- The NI informed us the vision for the service was to attract more patients and expand the services offered at the clinic accordingly. The current building work to extend the premises would create additional consultations rooms and was part of the plan to achieve the vision. The service had also secured planning permission for another extension to create 18 additional beds and two theatres. However, this was seen as a longer term plan and as such no dates had been set for this work to start.
- The NI and RM saw the soon to be established new transport links from the local train station as an advantage to the service as it would make the hospital more accessible to a larger number of patients.

Governance, risk management and quality measurement

- The hospital had an up to date policy, which included its statement of purpose and various other clinical and operational policies. Copies of the hospital policy was available to staff.
- Since our previous inspection, the RM had implemented a risk register highlighting the risks to the service and what mitigating arrangements were in place. However we noted the risk register did not include all the risks we identified during our inspection, such as the infection control risk due to the carpeted consultation room. This risk was highlighted in our previous report. The RM and NI told us this risk was being addressed by building new consultation rooms.
- We reviewed minutes from the medical advisory committee (MAC) meetings held in April and July 2016. The April meeting was not attended by any surgeon or anaesthetist. The July meeting was attended by the MAC chair, a surgeon, an anaesthetist as well as the NI and RM. We saw the chair discussed the requirement for all surgeons to be on the specialist register and have an up to date appraisal. It was unclear how decisions from the meeting were shared with other staff and who was responsible to ensure these were being complied with.
- The manager had introduced an audit programme but as they were the person overseeing all audits, we saw evidence re-audits were not always being done to compete the audit cycle. For example, we did not see evidence the IPC re-audit planned for April 2016 took place.

Leadership / culture of service related to this core service

- The organisation structure of the hospital was director, registered manager, deputy manager, marketing consultant/administrator, and receptionist.
- Staff we spoke with told us the RM was approachable and supportive and they commented on the positive changes implemented by the RM since her appointment. For example, IPC and consent audits.

Public and staff engagement (local and service level if this is the main core service)

- Patients could access a patient co-ordinator either by telephone or email to ask questions about treatments or pre or post-surgery advice.
- The NI chaired regular staff meetings attended by the RM, deputy manager and other administrative and support staff. We saw from minutes of these meetings that staff were able to contribute ideas and were encouraged to raise any concerns they had about the day to day running of the service. In the minutes we reviewed we saw that staff had open discussion, for example there was a discussion about the positive feedback from patients particularly mentioning the ward staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The Provider must ensure they operate an effective system or process which enables them to assess, monitor and improve the quality and safety of services provided in the carrying on of the prescribed regulated activities.
- The Provider must ensure they assess, monitor and mitigate the risks relating to health, safety and welfare of service users and others.
- Ensure the registered manager has access to relevant professional training and development and peer review.
- The Provider must assess the risks to the health and safety of service users receiving care or treatment and must do all that is reasonably practicable to mitigate any such risks. The Provider should ensure that policies and procedures meet with national and evidence based practice and recommendations where applicable.

Action the provider SHOULD take to improve

- The provider should ensure medicines are managed in a safe and proper way.
- Enable incidents or near misses to be discussed at meetings of the Medical Advisory Committee and shared with staff.
- Review the environment and infection control practices to ensure they meet with the Health Code. The provider should ensure the premises are suitable for the purpose for which they are being used.
- Fire extinguishers in the ward area should be properly secured in line with Regulation Reform (Fire Safety) order 2005.
- Take proportionate action, includingchanges of practice or learning as a result of investigating complaints.

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
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. **12.**—(1) Care and treatment must be provided in a safe way for service users. The provider was failing this regulation with regard to: Assessing the risks to the health and safety of service users of receiving the care or treatment. Doing all that is reasonably practicable to mitigate any such risks. This was because they: Failed to consistently follow local and national policies in relation to pregnancy screening and the use of early warning scores. Processes to monitor risk to patients and staff were not fully implemented. Incidents were not discussed at the Medical Advisory Committee. A robust procedure for checking dates of medicines and medical gases was not in place. Safeguarding children's policy was not up to date with recommended guidance. Regulation 12 (2) (a) and (b) The provider was failing to: Ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. This was because:

This section is primarily information for the provider

Requirement notices

Employed clinical staff had not been provided with intermediate life support (ILS) training, and the registered manager did not have the opportunity to receive peer review of their clinical competencies.

Regulation 12 (2) (c)

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance. The provider failed to: Assess, monitor and improve the quality and safety of the services provided. This was because the governance arrangements did not provided assurance of systematic monitoring of the quality of services. The risk register was not robust and did not reflect the risks to the organisation fully. Regulation 17 (2) (a) The systems and process to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk from the carrying out of the regulated activity were not operating effectively. The provider was failing in the regulations because: The service had not sought Infection prevention and control advice as part of the planning and building works.

This section is primarily information for the provider

Requirement notices

There was a lack of window restrictors, and the storage of fire fighting equipment was not sufficiently safe.

The number of incidents reported was low and there was a lack of oversight of post operative surgical site infections.

Policies were not reflective of current best practice.

Regulation 17 (2) (b)