Prem House Clinic Ltd

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Prem House Clinic is an independent hospital, based in Liverpool which provides surgical cosmetic services and is part of Prem House Clinic Limited. The majority of surgical procedures are day case breast augmentations but also blepharoplasty and abdominoplasty to patients over the age of 18 years of age are provided.

The hospital's senior management team consists of a director and the registered manager. Clinical advice is provided from the chair of the medical advisory committee (MAC).

We inspected Prem House Clinic as part of our comprehensive inspection programme and we carried out an announced inspection on 13 July 2016. At the time of our initial visit there was no surgery planned for the day. We also carried out an unannounced inspection on 18 July 2016, which was the first day surgery was planned following our announced inspection. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides. A warning notice has been issued to the provider setting out improvements that need to be made.

Are services safe at this hospital

- The majority of staff we spoke to were unaware what constituted an incident and issues such as, surgical site infections, which would be considered incidents, were not being reported. We were not assured that learning from incidents was being cascaded to staff to improve standards.
- The adverse incident management policy did not reflect the duty of candour requirements. There was a theatre standards policy but this was not always being implemented and the World Health Organization (WHO) five steps to safer surgery were not being followed in full.
- The processes and procedures for the safe management of medicines was not robust. We found that the prescribing of medication was not clear and there were occasions when medication had been given to patients more often than was recommended. There was also medication which did not have the expiry date on and medication that was dispensed for a specific individual was being used as medicine for other patients
- It was unclear if essential equipment had been regularly checked and there was suction tubing, two interlock connectors and yellow blood bottles in the resuscitation trolley that would be used in an emergency which were out of date. There were times when patient records were left unattended and the integrated care pathway documentation was not always being fully completed.
- There was a lack of guidance for staff on what to do following the completion of risk assessments.
- The out of hours service was not being monitored to measure its effectiveness and to improve standards in care. The majority of staff we spoke to were unaware how this service operated and a patient said they had been unable to access the service.
- Staffing levels and skill mix were planned and reviewed to ensure there was sufficient numbers of staff to provide safe care.
- There were good hand hygiene practices were observed and posters available for the public outlining how to wash their hands to help control infections. Environmental risk assessments were completed on an annual basis on all areas such as the ward and theatre.

Are services effective at this hospital

- Best practice guidance, such as those from the National Institute for Health and Care Excellence (NICE), was not always being clearly documented, especially in relation to undertaking routine pregnancy testing or asking patients if they may be pregnant, before procedures.
- Whilst food and drink was available for patients at the hospital the malnutrition screening tool, which was completed during consultation, did not outline the score correctly for staff to refer to for nutritional assessments.

Summary of findings

- The hospital was not monitoring patient outcomes effectively. There was not a review system in place to ensure that surgeons undertaking procedures were competent. Not all doctors were fully engaged with the annual appraisal process.
- The hospital were not routinely collecting and reporting on cosmetic patient reported outcomes(Q-PROMs) data which is a recognised tool to collect patient satisfaction with their operation.
- Patient pain was managed effectively and staff worked well together. Consent processes were based on national guidance. The hospital had a local audit programme in place.
- The Private Healthcare Market Investigation Order (2014) requires every private healthcare facility to collect a defined set of performance measures and to supply that data to the Private Healthcare Information Network (PHIN). Hospitals were required to collect this data from January 2016, ready for submission in September 2016. The hospital had a process in place to record this information and was aware of the requirement.

Are services caring at this hospital

- Patients were treated with dignity and respect and were fully involved in their care.
- Staff explained procedures to them in a way they understood.
- Patients spoke positively about the care they had received and had been given all the information they required.

Are services responsive at this hospital

- The facilities and premises were appropriate for the services that were planned and delivered. However, the anaesthetic room was not used and patients were anaesthetised in theatre. This meant they had to pass the recovery area and there were times when they saw other patients who were being recovered from surgery. One such patient was in distress and this caused anxiety in a patient awaiting surgery.
- Discharge arrangements were not always robust and the theatre standards policy was not always being implemented.
- There was a lack of policies for some key areas such as female genital mutilation and some policies contained inaccurate information.
- The hospital did not use the Independent Sector Complaints Adjudication Service which meant that the only process of appeal was for the complaint to be dealt with internally by the director.
- Consultation clinics were regularly monitored to make sure they were running on time. On rare occasions when clinics ran late, staff would ensure patients were kept informed. The hospital arranged appointment and surgery times to meet the needs of the individual patient.
- Information leaflets were available for patients and staff could access interpreter services if required.

Are services well led at this hospital

- There was a governance reporting structure with meetings being held on a monthly or quarterly basis. However, there was limited assurance that learning from incidents or complaints were discussed or disseminated to staff to help improve standards of care.
- There was no formal risk register in place to highlights risks to the service or outline how they would be mitigated in an effective and timely way.
- The hospital sought feedback from patients about the care received through their own surveys.
- Staff were positive about the leadership of the service and enjoyed working at the hospital.

Our key findings were as follows:

Incidents

Summary of findings

- The hospital had an adverse incident management policy and procedure. However, the majority of staff were unaware what constituted an incident. What would be considered incidents were not being reported. For example, patients returning to theatre or surgical site infections. We were not assured that learning from incidents was being cascaded to staff to improve standards. The adverse incident management policy did not reflect the duty of candour requirements.

Assessing and responding to risk

- The five steps to safer surgery were not being fully followed.
- It was unclear if the anaesthetic equipment and breathing circuits had been regularly checked and there were a number of consumable items in the resuscitation trolley that were out of date. There was suction tubing, two interlock connectors and yellow blood bottles
- Following discharge, patients could call the hospital for advice or reassurance. However, the calls to this service were not being monitored to look for trends to help improve standards of care. The majority of staff we spoke to were unaware how this service operated and a patient said they had been unable to access this service.
- Discharge arrangements were not robust.

Medicines

- The processes and procedures for the safe management of medicines were not robust. We found that the prescribing of medication was not clear and there were occasions when medication had been given to patients more often than was recommended. There was also medication which did not have the expiry date on.
- We found medicines that had been dispensed for a specific individual were being used as medicine for other patients and quarterly audits of controlled drugs had not highlighted issues with controlled drugs.

Records

- Patient records were left unattended at times which increased the risk of them being accessed by unauthorised personnel.
- The integrated care pathway documentation was not always being fully completed and there was a lack of guidance for staff following the completion of risk assessments.

Evidenced based care and treatment

- National Institute for Health and Care Excellence (NICE) guidance was not always being followed.

Competent staff

- There was a lack of monitoring of staff competencies.
- All doctors were not fully engaged with the appraisal process and mandatory training levels were low, especially in life support.

Access and Flow

- The patient journey through the hospital was not always as person centred as it could have been. As the anaesthetic room was not being used, patients had to pass the recovery area where patients who had just had their operation were recovering.

Complaints

- The hospital did not use the Independent Sector Complaints Adjudication Service which meant that the only process of appeal was for the complaint to be dealt with internally by the director.
- The complaints policy contained inaccurate information.

Governance and risk management

Summary of findings

- There was a governance reporting structure and the main governance committee was held on a monthly basis. However, learning from incidents or complaints or trends were not discussed to help improve standards.
- We saw no evidence that other doctors working at the hospital under practicing privileges attended the medical advisory committee to help give clear clinical oversight of the clinic.
- There was no formal risk register to identify potential risks to the organisation or to patients. This offered no assurance that risks were being mitigated in an effective and timely manner.
- Policies were not always being fully implemented, for example, the complaints policy contained inaccurate information. Policies were not available for some key areas, such as female genital mutilation.

There were areas where the provider needs to make improvements. A warning notice has been issued to the provider. Importantly, the provider must:

- Ensure there are effective systems and processes in place to assess, record and mitigate risks.
- Ensure processes are in place and followed to guarantee equipment for resuscitation are in date.
- Ensure there is a safe process in place for the management of medicines.
- Ensure safe storage of patients' records.
- Ensure staff adhere to all policies and ensure the theatre standards policy is fully implemented.
- Ensure the integrated care pathway documentation is completed accurately and the paperwork is correct, especially the malnutrition screening tool.
- Ensure that risk assessments include relevant guidance for staff.
- Ensure that relevant best practice guidance is implemented and ensure routine pregnancy testing or recording of patients last menstrual period is recorded in all cases.
- Ensure full compliance with the use of the early warning scoring (EWS) system and that staff are fully competent in the use of the system.
- Ensure that policies are reviewed to ensure they contain accurate and up to date information. Especially the complaints policy, discharge policy, admission policy and adverse incident policy together with developing a female genital mutilation policy.
- Ensure the service is meeting the recommendations from the Review of the Regulation of Cosmetic Interventions in relation to collecting QPROMS and SNOMED coding information.
- Ensure that all doctors have up to date appraisals.
- Ensure that all staff receive regular supervision meetings
- Ensure that all staff are up to date with mandatory training, especially in basic, intermediate and advanced life support as well as safeguarding training.
- Ensure that patient outcomes are fully monitored.
- Ensure that there are robust systems in place to ensure competencies of doctors performing surgery are regularly monitored.
- Ensure that incident processes and procedures are reviewed and that staff understand what constitutes an incident and that learning is identified and cascaded to staff to improve services.
- Ensure that the out of hours on call service is fully monitored to inform improvements in standards of care.
- Ensure that the patient journey is reviewed, especially from being anaesthetised to discharge.
- Ensure there are robust systems in place for the safe management of medicines.
- Ensure that a copy of the discharge information is sent directly to the patient's general practitioner.

In addition the provider should:

- Consider how doctors engage with the medical advisory committee.
- Consider how the responsible officer engages with governance meetings.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

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Services we looked at
Cosmetic Surgery

Summary of this inspection

Background to Prem House Clinic Ltd

Prem House Clinic is an independent cosmetic hospital, based in Liverpool and is part of Prem House Clinic Limited.

The hospital was registered with the Care Quality Commission in March 2012. It is a converted government building, with one theatre and seven beds in a self-contained ground floor clinical area. There is a shared reception area, and the hospital has the use of a treatment room and four consulting rooms.

The service is registered with the Care Quality Commission to carry out the following regulated activities:

- Treatment of Disease, Disorder and/or injury
- Surgical Procedures
- Diagnostic and Screening Procedures

The current registered hospital manager has been in place since January 2014.

The hospital provides cosmetic surgery for self-funded patients and all patients seen are over the age of 18 years of age. The majority of surgical procedures are day case breast augmentations but also blepharoplasty and abdominoplasty are provided.

We inspected surgery at the Prem House Clinic, as part of our ongoing programme of comprehensive Independent Health Care inspections.

Our inspection team

Our inspection team was led by:

Inspection Lead: Jacqui Hornby, Inspector, Care Quality Commission.

The team included two CQC inspectors, an inspection manager, a surgeon and a nurse.

How we carried out this inspection

To get to the heart of 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?

Before visiting, we reviewed a range of information we held about Prem House Clinic. We carried out an announced visit on 13 July 2016, during this visit there was no surgery planned. On 18 July 2016, we carried out an unannounced inspection of the hospital, when there were patients undergoing surgical procedures. We visited areas within the service including the theatre, recovery area, consultation rooms, waiting area and the ward.

We spoke with 12 staff including; registered nurses, health care assistants, medical staff, operating department practitioners, administrative staff and senior managers. We spoke with four patients. We also reviewed 22 sets of patient records and 13 staff records.

We would like to thank all staff and patients for sharing their views and experiences of the quality of care and treatment provided by Prem House Clinic.

We have not provided ratings for this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Summary of this inspection

Information about Prem House Clinic Ltd

In the reporting period April 2015 to March 2016 there were 735 surgical procedures performed. Of these, 35 required overnight stays and 700 were day cases (surgery which did not require an overnight stay). The four most common operations performed at Prem House Clinic were breast augmentation, rhinoplasty (plastic surgery to the nose), mastopexy (breast uplift) and abdominoplasty (removal of excess flesh from the abdomen).

Between April 2015 to March 2016, 2,465 outpatients were seen. Of these, 735 were for a first visit and 1,730 were seen for a follow-up visit.

The hospital had five surgeons, anaesthetists who worked under a practising privileges agreement and one regular resident medical officer (RMO) who was employed by an agency. It employed 4.8 whole time equivalent (WTE) registered nurses, 6.8 WTE health care assistants and operating department practitioners (ODP). It also employed a medical officer as well as having its own bank staff that included health care assistants and ODPs. There was also a complaints co-ordinator. The accountable officer for controlled drugs (CDs) was the registered manager.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Prem House Clinic provides cosmetic surgery for self-funding patients.

There are seven beds provided on the first floor. One single en-suite room, a two bedded en-suite room and a four bedded en-suite room. There is one operating theatre, a recovery area and an anaesthetic room.

On average, seven theatre lists run a month. In the reporting period April 2015 to March 2016 there were 735 surgical procedures performed. Of these, 35 required overnight stays and 700 were day cases.

Service level agreements were in place with the neighbouring acute NHS trusts to provide sterile services, pathology and haematology services including blood transfusion. There were also service level agreements in place with other organisations to provide services such as clinical waste and pharmacy services.

During our inspection, we visited the ward and operating theatre. We observed the care of patients on the ward, recovery area and during operative procedures in theatre. We spoke with 12 staff including; registered nurses, health care assistants, admin staff, medical staff, operating department practitioners, and senior managers. We spoke with four patients. During our inspection we reviewed 22 sets of patient notes and 13 staff records.

Summary of findings

- The hospital had an adverse incident management policy and procedure. However, the majority of staff were unaware what constituted an incident and issues that would be considered incidents were not being reported; for example, patients returning to theatre or surgical site infections.
- We were not assured that learning from incidents was being cascaded to staff to improve standards. The adverse incident management policy did not reflect the duty of candour requirements.
- The five steps to safer surgery were not being fully followed.
- It was unclear if the anaesthetic equipment and breathing circuits had been regularly checked and there were a number of consumable items in the resuscitation trolley that were out of date. Such as suction tubing, two interlocking connects and yellow blood bottles.
- The processes and procedures for the safe management of medicines were not robust. We found that the prescribing of medication was not clear and there were occasions when medication had been given to patients more often than was recommended. There was also medication which did not have the expiry date on.
- We found medicines that had been dispensed for a specific individual were being used as medicine for other patients.
- Patient records were left unattended at times which increased the risk of them being accessed by unauthorised personnel.
- The integrated care pathway documentation was not always being fully completed and there was a lack of guidance for staff following the completion of risk assessments.

Surgery

- Following discharge, patients could call the hospital for advice or reassurance. The calls to this service were not being monitored to look for trends to help improve standards of care. The majority of staff we spoke to were unaware how this service operated and a patient said they had been unable to access this service.
- National Institute of Health and Care Excellence (NICE) guidance was not always being followed and there was a lack of monitoring or patient outcomes and staff competencies. All doctors were not fully engaged with the appraisal process and mandatory training levels were low, especially in life support.
- The patient journey through the hospital was not always as person centred as it could have been. As the anaesthetic room was not being used, patients had to pass the recovery area where patients who had just had their operation were being cared for. Discharge arrangements were not robust.
- Policies were not always being fully implemented, for example the theatre standards policy, and some policies contained inaccurate information. There was also a lack of policies for some key areas, such as female genital mutilation.
- The hospital did not subscribe to the Independent Sector Complaints Adjudication Service which meant that the only process of appeal was for the complaint to be dealt with internally by the director.
- There was a governance reporting structure and the main governance committee was held on a monthly basis. However, learning from incidents or complaints or trends were not discussed to help improve standards. We saw no evidence that other doctors working at the hospital under practicing privileges attended the medical advisory committee to help give clear clinical oversight of the clinic
- There was no formal risk register to identify potential risks to the organisation or to patients. This offered no assurance that risks were being mitigated in an effective and timely manner.

However;

- Staffing levels and skill mix were planned, implemented and reviewed to ensure there was sufficient numbers of staff to provide safe care.
- Patient's pain was managed effectively.
- Staff worked well together with effective communication and consent processes were robust.
- Patients told us staff were caring, kind and respected their wishes. People we spoke with during the inspection were complimentary about the staff that cared for them. The hospital sought feedback from all patients regarding the care they had received.
- Staff spoke very positively about the leadership of the service, staff felt engaged and enjoyed working at the hospital

Surgery

Are surgery services safe?

Summary

- The hospital had an adverse incident management policy and procedure. However, the majority of staff were unaware what constituted an incident such as surgical site infections and were not always reporting incidents such as patients returning to theatre.
- We were not assured that learning from incidents was being cascaded to staff to improve standards.
- The hospital's adverse incident management policy and procedure did not reflect the duty of candour requirements, which came in force in April 2015. The duty of candour is a regulatory duty that relates to openness and transparency. Surgical site infections were not being recorded as incidents, but were reviewed by the infection control committee and it was unclear if any learning or actions identified had been implemented.
- It was unclear if the anaesthetic equipment and breathing circuits in theatre had been regularly checked and there were a number of consumable items in the resuscitation trolley that were out of date.
- The processes and procedures for the safe management of medicines were not robust. We found that the prescribing of medication was not clear and there were occasions when medication had been given to patients more often than was recommended. There was also medication which did not have the expiry date on.
- Prescriptions were being pre-printed and dispensed before the patient attended the clinic. This was for medication for pain and sickness. This meant there was a risk that patients may not get the appropriate medication when they needed it.
- Medicines that had been dispensed for a specific individual were being used as medicine for other patients.
- Patient records were left unattended at times which increased the risk of them being accessed by unauthorised personnel.
- The integrated care pathway documentation was not always being fully completed and accurate. This included the early warning scores and the world health organisation (WHO) checklist. The debriefing sessions following surgery were not always being undertaken as outlined in the five steps to safer surgery.
- Staff attended mandatory training courses but the compliance rates were low. This included basic life support and immediate life support. There was no training or policy in relation to female genital mutilation which is mandatory for health and social care professionals.
- The hospital had an admissions policy but this did not set out which patient groups would not be accepted for surgery, which meant there was a risk that patients who were at potentially high risk were admitted.
- Following discharge, patients could call the hospital for advice or reassurance. The calls to this service were not being monitored to measure its effectiveness and look for trends to help improve standards of care. The majority of staff were unaware how this service operated and a patient said they had been unable to access this service.
- The discharge policy did not specifically outline what observations levels were required before discharging patients and we saw a patient was discharged from the ward before they were fully recovered.

However

- Staffing levels and skill mix were planned, implemented and reviewed to ensure there was sufficient numbers of staff to provide safe care.
- The hospital reported no never events or venous thromboembolism (VTE) incidents
- Staff followed good practice guidance in relation to the control and prevention of infection policies and procedures and we observed good hand hygiene practice
- Environmental risk assessments were completed on an annual basis.

Incidents

- Between April 2015 and March 2016, there were no never events reported for this service. (Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented). There were also no serious incidents reported in this timeframe. Incidents were reported via a paper based system.
- The information provided by the hospital prior to inspection showed that there had been four clinical incidents reported between April 2015 and March 2016. The category of these incidents (no harm, low harm, moderate, severe or death) was not indicated. The

registered manager also reported at the time of inspection there had been no further incidents between March 2016 and the date of inspection. However, staff told us that there had been a further three incidents in the past eight weeks which they had emailed the registered manager about. However, they said they had not completed incident forms. The registered manager told us they were unaware of these incidents.

- Surgical site infections were not being recorded as incidents, but were reviewed by the infection control committee. We saw that for three surgical site infections a root cause analysis tool had been used to investigate the incident which outlined the event, timelines and staff involved in the incident. However, it was unclear if any learning or actions identified had been implemented as there was no indication of how the information should be shared with staff as outlined in the national patient safety guidance.
- We saw evidence in the theatre logbooks that patients had returned to theatre. Staff also confirmed this but they had not been recorded as incidents and there was no evidence of whether they were investigated, or whether lessons had been learnt to prevent recurrence.
- The hospital had an adverse incident management policy and procedure, and staff would report incidents on a paper-based incident reporting form. Staff were aware of this process. However some staff said they had reported incidents via email to the hospital manager.
- The majority of staff could not give clear examples of what they would report. For example staff said 'it would be anything that had not gone right'.
- Staff said that feedback would be provided to them at staff meetings, if any incidents were to occur. We reviewed the minutes of staff meetings between January 2016 and June 2016 and found no evidence that learning from incidents was discussed at these meetings. However, on reviewing the minutes of the clinical governance committee in April 2016 two incidents were discussed. We were not assured that learning from incidents was being cascaded to staff to help improve standards of care.
- There was a Duty of Candour(DoC) policy in place. The 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 came into force for independent health providers in April 2015. There was limited understanding of the duty of candour by staff we spoke to, including the registered manager.
- Staff told us they would be aware if patients were admitted into their local hospitals for complications following their surgery, as they would receive notification by the hospital. They stated they would document this information in the patient notes; however, they would not raise an incident in relation to this.
- Certain incidents, events and changes that affect a service or the people using it must be reported to the CQC in line with the CQC (Registration) Regulations 2009. The hospital did not have a policy for reporting such notifiable incidents. The hospital had not reported any notifiable incidents to the CQC between April 2015 and March 2016.
- At the time of the inspection, the registered manager told us that there would be a full review of incident management processes.

Safety Performance

- The hospital reported there were no incidents of venous thromboembolism (VTE) (a blood clot in a vein) between April 2015 and March 2016.
- The hospital monitored surgical site infection rates, through the infection control committee. Between October 2015 and March 2016 there had been 10 surgical site infections. Actions had been identified to improve care, for example to look at different ways to close wounds. However, there was no timeframe identified to complete actions which meant it was difficult to track performance.
- The number of surgical site infections were not reported on the infection control annual statement that was presented to the clinical governance meeting. This meant there was a risk that senior managers were not aware of actions being taken to reduce the number of surgical site infections.

Cleanliness, infection control and hygiene

- The hospital performed infection prevention and control audits regularly, which looked at cleanliness of equipment and the environment, cannula care, and hand hygiene. We saw evidence that actions were taken as a result of these. For example, ensuring that all staff received a copy of the five moments of hand hygiene.

- Department of Health (DH) guidance states that healthcare providers should be providing focused screening to patients that are deemed high risk or have a previous history of methicillin-resistant staphylococcus aureus (MRSA) infection or colonisation, and encourages providers to identify their own categories of high risk patients who would require screening. There was a clear MRSA policy in place which included high risk patients.
- The hospital undertook an annual audit of compliance with MRSA screening. In 2015 there was 100% compliance.
- Between April 2015 and March 2016 the hospital reported no cases of Clostridium Difficile, methicillin-resistant staphylococcus aureus (MRSA) or methicillin-susceptible staphylococcus aureus (MSSA).
- Staff generally followed good practice guidance in relation to the control and prevention of infection in line with policies and procedures. There was a sufficient number of hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked. We observed staff following hand hygiene practice, bare below the elbow and using personal protective equipment where appropriate. However, we did observe a nurse wearing nail varnish, which was not best practice.
- The ward used 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use. Staff we spoke with understood this labelling system.
- All the areas we visited were visibly clean and free from odour. We observed that cleaning of the environment was thorough.
- We observed that the disposal of sharps, such as needles followed good practice guidance. Sharps containers were dated and signed on assembly, and the temporary closure was used when sharps containers were not in use.
- Cleaning schedules were in place and had been completed as required, therefore reducing the risk of cross infection. This included a six weekly deep clean of the theatre area.
- We observed that in theatre there were a number of posters and information that had been put up on the walls with adhesive substance which increased the risk of infection from dust or dirt being trapped behind the posters. We raised this with the registered manager who immediately removed the posters.

Environment and equipment

- In order to maintain the security of patients, visitors were required to use a bell system outside the ward to identify themselves on arrival before they were able to gain access.
- Resuscitation equipment was available and the hospital's policy stated this equipment must be checked prior to each surgical list and recorded that it was in working order. We saw records which indicated that this check did occur. However, during our inspection, we saw a number of consumable items had expired, for example suction tubing and interlock connectors. This meant staff were not thoroughly checking the expiry dates of consumables during the checking process. In addition, there wasn't a list of what equipment should be included on the resuscitation trolley as standard.
- These issues were raised with the theatre manager at the time of the inspection. The out of date items were promptly disposed of. We checked the equipment again on the unannounced inspection and found that all the equipment was in date and a new checklist had been developed to show what equipment should be present on the trolley.
- All the areas we visited were bright and well organised and each ward area had designated toilets and showers.
- All equipment had been appropriately maintained and serviced. For example, we checked equipment such as electronic blood pressure machines; all had been serviced within the past year and where necessary, had been safety tested.
- The theatres had its own anaesthetic equipment and breathing circuits, but it was unclear when this was last checked. The registered manager informed us that this was changed weekly but the anaesthetic machine log book has not been completed to reflect this. On the unannounced inspection we saw that a new log book had been implemented to ensure that both the anaesthetist and the assistant signed the book when the daily and weekly checks had been completed.
- The hospital had a service level agreement with a local acute NHS trust, for the sterilisation of reusable sterile items.

- Environmental risk assessments of the ward and theatre areas were completed on an annual basis.

Medicines

- The hospital had a service level agreement with a local pharmacy to supply stock medicines. If patients were prescribed a non-stock item, this was ordered and collected. Medicines for patients to take home were obtained from the local pharmacy.
- The hospital had medicines management policy that included medicine storage and administration. This was discussed at the last drug and therapeutic committee in December 2015. However, we could not see any evidence that this had been agreed through the governance structure and it still had the word draft on the documentation.
- The process for recording patient PRN medication (medication that is used only when required) and the hospital stock medication was unclear as they were being recorded in the same book but not separated by either stock medication or patient medication. This meant there was a risk that staff would not accurately know how much medication was available.
- Each patient had a file that contained standard patient medication forms that were signed by the surgeons prior to surgery. We saw case notes for two people who were attending surgery in the future all had the PRN forms in the back signed in advance. In addition, the PRN files listed a number of medicines but full details were not available. As an example Codeine Phosphate was listed as codeine. There was no strength or route of the medication (how it should be given either orally or intravenously). There was no information as to when to give the pain relief, what dose was to be given or what medicines could be taken in conjunction with others.
- We reviewed seven patient records and found that anaesthetists were not always documenting the times of when medication was given. In five of the records it was unclear whether medication was given at the time of the operation or on the ward. Two of the five records clearly showed that medication was given during the operation but it was given again on the ward, in excess of the recommended doses. The route that the medication was to be administered was also not recorded.
- The hospital used pre-printed pieces of paper as prescriptions in order to obtain medicines from the local pharmacy to give to patients on discharge. Staff told us these were printed off the computer ahead of the patient attending the clinic. This meant there was a risk that incorrect medication could be obtained from the pharmacy. It is good practice to record the use of prescription sheets, however this was not done. After the inspection, we were informed by the registered manager that this practice no longer happens and additional checklists have been put in place to ensure take home medicines are correct and auditable.
- At the time of the inspection we observed there were some medicines that had been dispensed for a specific individual, with their name on the medication, being used as PRN medicine for other patients. At the time of the inspection, the manager was unaware of where these came from. It is not considered best practice to utilise medicines dispensed for one person and use them for another.
- We also found some strips of tablets that had been cut from the main packet. When they were cut off from the main strip, it left the remaining packet without any expiry date on and this meant there was a risk that staff would not know whether the medicines were in date and fit for use.
- There had been recent incidents of doctors sharing controlled drug ampules for different patients during surgery which we were told had stopped just before the inspection. Quarterly external audits had been undertaken by the pharmacy but these had failed to highlight the issue. Quarterly internal audits were being implemented.
- National Institute of Health and Care Excellence (NICE) quality statement 61 states that patients are prescribed antibiotics in accordance with local antibiotic protocols in order to reduce the risk of unnecessary prescribing that could increase the resistance of bacteria. The hospital did have local guidance for the prescribing and administration of antibiotics although this was relatively new and drafted three months prior to the inspection and not all staff were aware of it. There wasn't any audit on the use of antibiotics included on the audit programme for 2016.
- Medicines requiring cool storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Daily temperature checklists were only completed on three occasions between 1 July 2016 and 13 July 2016. This was because there were only three occasions when operations were carried out.

Surgery

Records

- Patient records were stored in the ward office; there were times when the office was left open and unattended which meant that there was a potential for the records to be accessed by unauthorised personnel. Patient records were also left unattended by the bed before patients had been admitted to the ward.
- All information was recorded in a single patient record; this was accessible by all staff and aided communication between the different professions.
- The hospital had a records policy which outlined standards of record keeping. It also included an audit tool for checking standards.
- In November 2015, a records audit was completed on five randomly selected records. The results showed that only 40% of the integrated care pathway documentation were fully completed and accurate. However, 100% did have clear patient identification and entries were signed and dated. The action taken to improve standards was to send a copy of the audit result and record keeping policy to staff. There was no action to put additional training in place to help improve standards.
- Record keeping training was available for staff and was required on a three yearly basis. However, the compliance rate at the time of the inspection was very low at 13%.
- We reviewed seven records for the completion of the integrated care pathway documentation and found that none of them were fully completed and accurate.
- We reviewed an additional 22 patient records and saw that information recorded was legible and contained information for patients' care and treatment. They also included risk assessments that were completed on admission.

Safeguarding

- There was a vulnerable adult protection policy. However, this did not provide details as to the level and type of training required for staff. There was a safeguarding children's policy to provide guidance for staff if they had any concerns regarding vulnerable children. Safeguarding training was mandatory for all staff; this was provided by an external company on an annual basis. However, at the time of the inspection the compliance rate was very low at 20%. Records provided by the hospital did not stipulate what level of safeguarding training had been undertaken which meant it was not clear what level staff were trained to.
- Staff said they had not needed to raise any safeguarding concerns but if they did, they would speak to their manager. The registered manager was the safeguarding lead.
- There was no reference in the hospital's safeguarding policy in relation to female genital mutilation (FGM) and staff had received no training in the subject. In October 2015, it became mandatory for regulated health and social care professionals to report 'known' cases of FGM, in persons under the age of 18, to the police. Whilst the service did not provide care to those patients under the age of 18, healthcare staff had a professional duty to report any concerns where a parent has had FGM and may have female children.

Mandatory training

- All staff were required to undertake mandatory training, which included health and safety, moving and handling, infection prevention and control, life support and food safety. This training was provided by an external company and was either on an annual basis or three yearly basis, depending on the module.
- Information provided by the hospital showed at the time of the inspection, 17% of staff were compliant with their annual training and 26% were compliant with their three yearly training.
- Of concern was only 56% of staff were compliant with basic life support and 16% were compliant with immediate life support. Both of these subjects were on an annual basis. There was no record of any theatre staff having advanced life support (ALS) training that is required if carrying out procedures that required sedation. The resident medical officer (RMO) confirmed that he had undertaken advanced life support training from the agency which employed him, though they were only based on the ward and not observed to be in the recovery area.

Assessing and responding to patient risk

- The hospital had an admissions policy but this did not set out which patient groups would not be accepted for surgery, which meant there was a risk that patients who

were potentially at high risk would be admitted. However, staff said that consultants screened patient with co-morbidities to see if they were fit to undertake surgery at the clinic.

- The National Institute for Health and Care Excellence (NICE) quality standard three requires that all patients receive an assessment of their risk of developing venous thromboembolism (VTE). The assessment should use defined clinical risk criteria. Information sent to us prior to inspection stated that 100% of patients had a VTE screening for the period April 2015 to March 2016. We reviewed the records of seven patients, and saw that a formal risk assessment for VTE had been performed.
- The Royal College of Surgeons (RCS) professional standards for cosmetic surgery (2016) state the surgeon should make an attempt to identify psychologically vulnerable patients and to consider psychological referral if a patient has co-existing psychological disturbances. We reviewed seven records to see if this had been documented. In one of these records, it was noted the patient had received treatment for anxiety and depression recently. However, no further psychological health assessment had been considered.
- Staff routinely assessed patients for their risk of pressure ulcers, by using the Waterlow risk assessment. We saw assessments had been documented in six out of the seven patient records we reviewed. However, the documentation did not provide guidance for nurses about what action to take with the scores.
- Staff undertook a manual handling risk assessment for patients prior to surgery.
- The World Health Organization (WHO) Surgical Safety Checklist was introduced in 2008. This is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway. The hospital did use this but we observed that this was not fully completed during surgery and there was no confirmation of the procedure to be undertaken. In all of the seven patient records we reviewed the timings of the procedures were not in the patient record and only held in the theatre register. This meant that all information regarding patient care was not held in the patient record.
- The National Patient Safety Agency (NPSA) five steps to safer surgery (2010) provides guidance to help reduce harm in perioperative care. This includes a briefing session before a surgical list and a debriefing session after the surgical list. Whilst we observed the briefing session was undertaken, staff said the debriefing session did not happen. There was a formal template for staff to complete for the briefing session and the debriefing session although this did not always happen.
- Since the inspection the registered manager said that further training would be given and they would attend the daily end of day debriefs when they were on site at the hospital to ensure these were being completed.
- A national early warning score system (NEWS) was used at the hospital to alert staff if a patient's condition was deteriorating. This is a basic set of observations such as respiratory rate, temperature, blood pressure and pain score, which is used to alert staff to any changes in a patient's condition.
- We reviewed 12 patient observation records and found that ten of these had not been completed accurately. For example, on two records not all observations had been recorded, which meant that the NEWS score could not be calculated and on eight records the NEWS scores had not been accurately calculated. NEWS audits were not carried out prior to the inspection and staff competency in calculating NEWS scores was not checked. We raised this with the registered manager who had put in additional training for staff before the unannounced inspection and a daily audit tool had been developed.
- There was a procedure in place for a patient to be transferred to the local acute NHS hospital if their condition deteriorated. There was a formal written transfer agreement, as required by the Independent Healthcare Advisory Services (2015). Staff told us they had a number to contact the local trust if they needed to transfer a patient. If the patient deteriorated quickly they would call for an emergency ambulance. Between April 2015 and March 2016 there had only been two unplanned transfers to another hospital.
- Within the patient's rooms there was a nurse call bell system and there was an additional light system to indicate which room the emergency had occurred in. However, in the recovery area at the time of the inspection, we saw that staff were unable to reach the call bell whilst assisting an agitated patient and had to call out for help. This was due to there being only one member of staff in the recovery area.
- Following discharge, patients could call the hospital for advice or reassurance. Out of hours, this call was answered by staff or the medical officer on a rota basis. However, a patient said that they had tried to phone the

number for help and it went unanswered so they went to the local NHS acute hospital for help. We asked if the out of hours calls were logged and monitored and we were informed that they were not but all patient information was recorded in their records. Since the inspection the registered manager told us that a monitoring system was being put in place to help analyse trends and issues to help improve standards of care.

- The patient journey was not always person centred. Staff said patients were normally discharged about four hours after surgery if they were well enough to go home and their observations were normal. We reviewed seven patient records and found that one patient was discharged within two hours and 20 minutes of having surgery despite records showing that they were feeling unwell. The discharge policy did not give clear guidelines in relation to observations and when it would be safe to discharge patients. It only stated when observations were satisfactory.
- There was a pathway and service level agreement in place with a NHS Trust for access to blood in the event of a patient requiring blood transfusion during a procedure

Nursing staffing

- Staffing on a day to day basis was reviewed by the registered manager and nurse manager.
- The hospital employed 4.8 whole time equivalent (WTE) registered nurses, 6.8 WTE operating department practitioners (ODP's) and health care assistants. Staff were contracted set hours per week, but worked flexibly depending on the needs of the organisation. Staff we spoke with were happy with this arrangement.
- Within the ward area, there was one registered nurse and two care assistants on during the day. On nights when the ward remained opened; there was one registered nurse and one care assistant. However, this meant there may be a risk to patients if the registered nurse needed to take a break and the care assistants needed help with a patient.
- In addition to the contracted staff, other staff were employed via the hospital's bank process, this ensured continuity of regular staff attending. On some occasions, the hospital used staff from an external agency.
- We reviewed the use of agency and bank nurses between April 2015 and March 2016 and found there were a number of occasions which used temporary staff regularly. For example, the average number of shifts filled with temporary nurses was 17% which was mainly higher than the yearly average of other independent hospitals we hold this data for. The average number of shifts filled with temporary health care assistants was 2% which was lower when compared to other independent hospitals we hold this data for. Bank and agency staff undertook a local induction when commencing work at the hospital.

Surgical staffing

- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (such as in the NHS) in substantive posts and had practising privileges with the hospital.
- The consultants and anaesthetists were responsible for their individual patients during their hospital stay.
- On days of surgery, a resident medical officer (RMO) was on duty and would stay overnight on the hospital premises when the ward remained opened. There was one main RMO, who covered the hospital. The RMO was employed by an external agency.
- When a new RMO started, their curriculum vitae (CV) was sent by the provider company to the director of clinical services for review, agreement and sign off prior to them commencing work at the hospital. The CVs included evidence of employment history, references, general medical council (GMC) details along with occupational health information and training, including advanced life support certificates.
- There was a surgeon or anaesthetist available who could get to the hospital premises within 30 -40 minutes in case there were any complications or patients needed to return to theatre out of hours. This was normally the person who had performed the procedure.

Major incident awareness and training

- There were documented major incident plans within the hospital and these listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident. However, there was no evidence that there had been major incident exercise in the past 12 months.
- The service had back up emergency generators in place should there be an unexpected power outage.

Surgery

Are surgery services effective?

Summary

- National Institute for Health and Care Excellence (NICE) guidance was not always being followed and the malnutrition screening tool did not outline the outcome correctly for staff to refer for nutritional assessments.
- The number of operations performed was collected but the hospital was not monitoring the patient outcomes effectively. They were not routinely collecting and reporting on Q-PROMs data, which is a recognised tool to collect patient satisfaction with their operation.
- Staff had an annual appraisal but not all doctors were fully engaged with the process.
- There wasn't a review system in place, apart from annual appraisals to ensure that surgeons undertaking procedures were competent and there were times when the revision rate of operations was relatively high when compared with data from similar organisations.
- The was a procedure in place to ensure patients were able to give informed consent. However there were concerns that a relative had been used as a translator when the hospital was seeking consent.

However;

- Patients' pain was managed effectively.
- Staff worked well together with effective communication and partnership working between the different professional groups

Evidence-based care and treatment

- Staff told us they were aware of National Institute of Health and Care Excellence (NICE) guidance and evidence-based practice.
- The hospital had recently completed a baseline self-assessment tool for controlled drugs (NICE medicines practice guidelines NG46) which showed that the hospital assessed themselves as meeting a 100% of the recommendations at the time of the inspection.
- Patient records confirmed that the date of the last menstrual period was recorded. However, it was unclear from the records if discussions about the possibility of being pregnant were discussed and recorded and a pregnancy test carried out if there was any doubt. There was a formal pathway in place. It was unclear if the service was always following NICE guidelines NG45.
- Regulations stated in the Department of Health (2013) Review of the Regulation of Cosmetic Interventions recommends that hospitals keep electronical details of implants used, which should be easily accessible in the case of a product recall. The hospital used a paper based system to record all implants used. However, they had registered with the Health and Social Care Information Centre (HSCIC) to be involved in the national breast and implant register when the system is up and running.
- The hospital had a local programme that included audits relating to post-operative nausea and vomiting (PONV), handwashing and records management.

Pain Relief

- Staff administered simple oral analgesia for patients on the wards. If the patient required stronger pain relief this would be prescribed by the anaesthetist or the registered medical officer (RMO).
- We observed staff regularly reviewed patients' levels of pain following surgery. If a patient was experiencing pain, staff administered pain relief and checked this had the desired effect.
- Records demonstrated that nurses regularly assessed a patient's pain post operatively using a pain scoring system.
- Patients told us staff were quick to respond to pain and would be given pain relief immediately if this was asked for.
- The hospital completed a pain audit in February 2015. The results showed that 79% of patients had effective pain relief and there was a recommendation to do a further audit but this was not on the audit programme for 2016. This meant the opportunity to review and improve standards for pain relief was not currently identified.

Nutrition and hydration

- A malnutrition screening tool was used to assess patients' nutrition but it outlined that if the nutrition score was less than two, staff should refer patients for a nutrition assessment. However, this should be if the score was more than two. Pre admission information for patients gave clear instructions on fasting times for food and drink prior to surgery. Admission times were staggered so patients were not fasting for longer than was considered necessary and was in line with the Royal College of anaesthetists guidelines.

- Following their procedure, patients were provided initially with drinking water and when they were fully recovered, staff provided snacks such as toast, sandwiches, soup or meals.
- Any special dietary requirements, intolerances or allergies were identified on the patient's record, and if required the staff would provide an appropriate meal.
- Staff were aware of the importance of ensuring patients received medication to prevent post-operative nausea and vomiting (PONV) and the importance of monitoring the nutrition and hydration post-operatively. We saw records where medication had been given to patients with PONV.

Patient outcomes

- The hospital had an audit programme that included some audits on patient outcomes. These included for example post-operative nausea and vomiting (PONV), pain management and patient satisfaction.
- We reviewed the PONV audit for 22 patients which was undertaken in April 2016. The report showed all patients received medicines to prevent nausea and vomiting during their operation and were also prescribed these post-operatively as well. The percentage of patients who experienced nausea and vomiting was 11% and the percentage who experienced nausea alone was 29%.
- The hospital collected surgical information which listed the number of operations performed by the surgeons including the number of revisions of surgery. This monitored the number of operations rather than patient outcomes. Revisions of surgery is usually undertaken when there have been complications or if the surgery was not in line with the patient's expectations"
- Between June 2015 and June 2016 the overall revision rate was 8%. However, for one surgeon, the revision rate was 23%. The national rate of revisions is between 5% and 8%.The registered manager said this was probably due to the complexity of the procedures being undertaken by the surgeon but there was no formal review of this.
- The Private Healthcare Market Investigation Order (2014) requires every private healthcare facility to collect a defined set of performance measures and to supply that data to the Private Healthcare Information Network (PHIN). Hospitals were required to collect this data from January 2016, ready for submission in September 2016. The hospital had a process in place to record this information and was aware of the requirement.
- The Royal College of Surgeons (RCS) recommends that providers routinely collect and report on Q-PROMs for all patients receiving procedures such as breast augmentation (enlargement) and blepharoplasty (cosmetic surgery to the eyelids). Q-PROMS are patient report outcome measures, which describe the level of patient satisfaction with certain operations. The hospital did not use the Q-PROMs recognised tool to collect patient satisfaction with the operation.

Competent staff

- Surgeons working at the hospital did so under 'practising privileges'. Practising privileges refers to medical practitioners not directly employed by the hospital who have permission to practise there. The hospital had a policy for granting and reviewing practising privileges. All doctors who worked under practising privileges provided evidence of their disclosure and barring service (DBS) checks and indemnity insurance. This was verified by the hospital's medical advisory committee (MAC). We reviewed the personal files of doctors working at the hospital and saw that practicing privileges arrangements had been recorded.
- The majority of staff told us they had received their appraisal. Between April 2015 and March 2016 100% of nurses and health care assistants had received their appraisal. However, only 67% of other staff, such as operating department practitioners had received their appraisal.
- We reviewed the records for the doctors with practising privileges and saw they had an up to date appraisal. However, two doctors who were employed by the hospital (but did not undertake surgery), did not have an up to date appraisal. The responsible officer said that they were now beginning to engage in the appraisal process but there had been difficulties in the past.
- From April 2016, all registered nurses were required to revalidate with the Nursing and Midwifery Council (NMC) in order to continue practising. The hospital was drafting a nursing revalidation policy which was to be approved by the clinical governance meeting at the end of July 2016.
- The hospital had a system in place to check the competency of surgeon's on starting at the hospital but apart from annual appraisals, there was no review system in place to ensure that surgeons and anaesthetists undertaking procedures were still

competent to perform them. This meant there was a risk that surgeons/anaesthetists may not be competent to carry out all procedures offered at the hospital and the service had not begun to have an overview of the operative exposure in the area of certification as recommended by the royal college of surgeons.

- There were nursing and healthcare support worker staff competencies kept on the ward which included competencies in wound care and medicines administration. However, the theatre manager said they were unaware of the competencies for staff that they were responsible for. For example nurses and operating department practitioners.
- Staff we spoke with confirmed they had an adequate induction. Newly appointed staff said their inductions had been planned and delivered well.
- Staff had been supported to undertake further training, for example the theatre healthcare assistant had been supported to undertake an apprenticeship framework qualification.
- The hospital had recently been authorised as a designated body with NHS England and the General Medical Council. A designated body supports staff with appraisals and revalidation in an environment that monitors and improves quality.

Multidisciplinary working

- We observed all staff working well together with effective communication and partnership working between the different professional groups.
- There was a service level agreement (SLA) in place with the local acute NHS hospitals and organisations for sterile services, pharmacy and pathology services. Staff told us these agreements worked well and they had not experienced any difficulties with any of these services.
- Staff were aware of which consultant had overall responsibility for each patient.

Seven-day services

- The hospital was not open every day but it provided flexibility and performed surgery on days that were suitable for the patients. This often included operations being scheduled at the weekend.
- Pharmacy services were available six days a week; 9am to 7pm, Monday to Friday and 9am to 5.30pm on a Saturday.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including, risk assessments, and medical and nursing records.
- There were computers available on the wards we visited, which staff accessed for patient and hospital information.
- All information about a patients care was held in their medical records and retained at the clinic.
- Policies, protocols and procedures were kept on shared drives on computers which meant staff had access to them when required.
- On the ward there were files containing minutes of meetings, ward protocols and audits, which were available to staff.
- The hospital did not directly communicate with patients' GPs. Patients were given a discharge letter which detailed the operation performed and the medicine the patient had been sent home with. Patients could choose to pass this letter on to their GPs if they wished. This practice is not in line with the recommendation made in the Review of the Regulation of Cosmetic Interventions (2014) which stated that details of the surgery and any implant used must be sent the patient's GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All patients were given a two week cooling off period between initial consultation and the procedure. This was in line with the RCS professional standards for cosmetic surgery (2016).
- Staff had the appropriate skills and knowledge to obtain consent from patients. The staff we spoke with were clear on how they sought verbal informed consent and written consent before providing care or treatment. We saw written records that indicated consent had been obtained from patients prior to procedures or treatment. We saw that there was a two stage consent process in place. This allowed patients time to reflect on the decision and followed the professionals' standards for cosmetic practice.
- However, we saw an example where consent had been obtained by using a relative as an interpreter. A patient had been asked to sign a disclaimer to say the surgeon had advised them against the procedure, was not liable for the result and they understood the risks. As a relative had been the interpreter on this occasion, staff said they

were unsure how much the patient had understood the situation before signing the disclaimer and consent forms. Staff had escalated this issue to the registered manager but we were not assured that this had been investigated.

- Staff said the use of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) did not need to be considered as only patients with full capacity would be admitted. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. We did not see any records where patients who lacked capacity were admitted to the hospital.

Are surgery services caring?

Summary

- Patients told us staff were caring, kind and respected their wishes. We saw that staff interactions with people were person-centred. People we spoke with during the inspection were complimentary about the staff that cared for them.
- Patients received compassionate care and their privacy and dignity were maintained.
- Patients were involved in their care and kept informed of the care and treatment. Staff explained procedures to them.

Compassionate care

- Without exception, patients told us that staff were kind, caring and professional.
- Feedback from patients we spoke to was consistently positive about the care and treatment they had received. Patients told us they would recommend the hospital to their friends and family.
- One patient told us how they felt safe and confident whilst being cared for by staff.
- Patients told us they were treated in a dignified and respectful manner. All members of staff introduced themselves to patients. We saw that staff respected a patient's privacy by always knocking on doors before entering or closing the curtains when providing direct care.
- We saw staff regularly going into the patients' rooms to check on how they were recovering, and ask if there was anything they needed.

Understanding and involvement of patients and those close to them

- Patients told us that all staff explained what they were doing in a way that they understood. If they did have any questions, they felt comfortable to ask. Patients said they were provided with a lot of information and staff explained this thoroughly.
- Discussions around the cost of procedures were always approached with sensitivity.
- We saw family members were encouraged to visit patients if they had to stay overnight and were included in conversations when appropriate.
- If patient's needed to stay overnight they were given a choice of which room they would like so that their individual needs were met and to maintain their privacy and dignity appropriately.

Emotional support

- Staff provided ongoing emotional support to patients when they were discharged from the hospital. If there were any issues that patients were concerned about, they had the option to contact the staff and arrange for an appointment at the hospital if required.
- We observed ward staff accompanying patients to the theatre and remaining with the patient until they had been fully anaesthetised. During this time, they provided emotional support and comfort to the patient.

Are surgery services responsive?

Summary

- Staff were not using the anaesthetic room which was adjacent to the theatre; instead, patients went straight into theatre to be anaesthetised. As a result, patients had to pass the recovery area which meant they sometimes saw other patients in distress.
- The theatre standards policy did not provide clear guidelines about when to transfer patients to the ward from the recovery area whilst suffering side effects of a general anaesthetic.
- The complaints policy contained out of date information as it referred to the CQC being an external

adjudicator for complaints. The policy made no reference to what would happen if the complaint was upheld or how to involve the police or other agencies if a serious concern was raised through a complaint.
- The hospital did not subscribe to the Independent Sector Complaints Adjudication Service which meant that the only process of appeal was for the complaint to be dealt with internally by the director.

However;

- The hospital arranged appointment and surgery times to meet the needs of the individual patient.
- Patients were kept informed if consultation clinics were not running on time.
- Information leaflets were available for patients and staff could access interpreter services if required.

Service planning and delivery to meet the needs of local people

- The facilities and premises were generally appropriate for the services that were planned and delivered. The hospital arranged appointments and surgery on dates and times that suited the individual patient.
- Within the last 12 months there had only been one cancelled procedure for a non-clinical reason. The patient was offered another appointment within 28 days.
- We observed a patient that was agitated in the recovery area following their procedure. This can be a side effect of a general anaesthetic. Due to patients going straight into theatre to be anaesthetised via the recovery area, another patient observed the distress the patient was in and became unsettled themselves. However, there was a separate anaesthetic room adjacent to the theatre which was not used. This meant that the patient journey was not always being considered.

Access and flow

- Between April 2015 to March 2016 there were 735 surgical procedures performed. Of these, 35 required overnight stays and 700 were day cases.
- Consultation clinics were regularly monitored to make sure they were running on time. On rare occasions when clinics ran late, staff would ensure patients were kept informed.
- Patients were transferred from recovery to the ward area very quickly and we observed a patient who was still agitated following the anaesthetic being transferred to the ward. The theatre standards policy did not provide clear guidelines when to transfer patients to the ward who were agitated following a general anaesthetic
- If a patient needed to be unexpectedly return to theatre whilst they were an inpatient, a consultant and anaesthetist was on call who could get to the clinic within 30- 40 minutes.
- If a patient required unexpected care following a day case, then they would be required to attend the local accident and emergency department. However, there was an on-call out of hours phone line service available for advice following discharge.

Meeting people's individual needs

- Call bells were available for patients to use and we saw that they were responded to quickly.
- Staff were able to access interpreters via language line if required although there had been an occasion when a family member had been used as an interpreter, which is not considered best practice.
- Staff said that they would not provide surgery for patients living with a cognitive impairment, such as dementia. However, this was not formally outlined in the admission policy.
- Information and leaflets were available for patients about services and the care they were receiving. These included the patient journey outlining what would happen on admission and in recovery with a list of side effects.
- There were no systems in place to provide support for religious and spiritual needs. However, patients would only be in for a short period of time.
- There was access to psychology support if required.

Learning from complaints and concerns

- The hospital had a complaints policy and procedure which outlined the process following the receipt of a complaint. The initial complaint was acknowledged in writing and a full written response would be completed within 20 working days of the complaint.
- Leaflets detailing how to make a complaint were readily available for patients and relatives.
- The complaints policy contained out of date information as it referred to CQC being an external adjudicator for complaints that could not be resolved between the patient and the service. This is incorrect and it is not the role of the CQC to adjudicate in such

cases. In addition, the policy made no reference to what would happen if the complaint was upheld or how to involve the police or other agencies if the complaint contained concerning information.
- The hospital did not subscribe to the Independent Sector Complaints Adjudication Service which meant that the only process of appeal was for the complaint to be dealt with internally by the director.
- From April 2015 to March 2016, there had been 25 complaints from patients which was a decrease from the previous year of 36.
- Complaints were discussed at the clinical governance committee meetings and the hospital medical advisory committee meetings (MAC) to monitor how complaints were being handled. However, there was no evidence of learning being discussed or shared with staff.

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Are surgery services well-led?

Summary

- There was no clear strategy for improving patient care or experience; however there was a business plan for the hospital.
- The hospital had not made any arrangements to put a plan in place to ensure that surgical cosmetic procedures were coded in accordance with SNOMED_CT which is to be implemented in 2020.
- Patient report outcomes measures (Q-PROMS) information was not collected from patients meaning that there was limited evidence that the quality of surgery was being measured.
- There was a governance reporting structure and the main governance committee held meetings on a monthly basis. However, learning from incidents and complaints were not discussed and there was no trend analysis to help improve standards. Actions from the meeting were identified but the date for completion was not identified which meant it was difficult to track progress.
- There was no formal risk register to identify risk potential risks to the organisation, or to patients. We were not assured that risks were being identified, managed or mitigated in an effective and timely manner.
- Not all staff could recall the last supervision they had received and some staff were unaware of the competencies of staff they managed.

However;

- Staff spoke very positively about the leadership of the service, staff felt engaged and enjoyed working at the hospital
- The hospital sought feedback from all patients regarding the care they had received.

Vision and strategy for this this core service

- The vision of the hospital was to provide a safe, caring and responsive service that was well led and cost effective. This was available on notice boards for staff and the public to see.
- There was no strategy for the hospital to improve standards for patient safety. There was a business plan in place which outlined the financial forecast for the organisation.
- The hospital had not drafted any plans to ensure that surgical cosmetic procedures were coded in accordance with SNOMED-CT. This is due to be fully implemented in the independent sector in April 2020. SNOMED-CT uses standardised codes to describe cosmetic surgical procedures, which can be used across electronic patient record systems.

Governance, risk management and quality measurement for this core service

- There was a governance reporting structure and the main governance committee was held on a monthly basis. Complaints and incidents were discussed although this was about the facts rather than any learning or trends to help improve standards. Actions were identified but the date the action was to have been completed (in order to help track progress) was not always clear.
- Staff were not able to tell us how their performance was monitored and what was discussed at the governance meeting.
- Staff meetings were held regularly. Minutes of the meeting showed that complaints and audits were discussed but not always incidents. There was also a copy of the minutes in a file on the ward for staff to read.

Surgery

- There were hospital medical advisory meetings (MAC) every three months. These meetings were attended by a surgeon and the registered manager. We saw evidence that risk assessments, audit results and complaints, for example, were discussed.
- The terms of reference for this meeting included all doctors who had practicing privileges as members; however, we saw no evidence that any other doctors had attended the meeting. This meant there was a risk that there was limited clinical engagement.
- There was no formal risk register to identify risk potential risks to the organisation or to patients. Risks were dealt with as and when they occurred.
- We reviewed a total of 13 staff files and saw evidence that disclosure and barring service (DBS) checks had been completed and all doctors had indemnity insurance.
- Whilst there was a governance structure in place the processes surrounding this structure were less formal than would be expected. For example, the duty of candour was not referenced in the adverse incident policy; there was a lack of competency checks for staff and lack of internal audits for the management of controlled drugs and early warning systems.

Leadership and culture of the service

- Staff we spoke with said they were well supported by their managers who were visible. They also told us that the management team were approachable and that they would feel comfortable raising any concerns they may have.
- All staff spoke positively about the leadership within the hospital and said they felt valued and respected. They enjoyed working in the team and enjoyed working at the hospital.
- Not all staff could recall the last supervision they had received. The theatre manager said that they had not provided regular supervision nor checked on staff practices as the staff had worked there for several years.
- Between April 2015 and March 2016 there were no staff vacancies and staff turnover was at 0%. Sickness levels were also at 0%.

Public and staff engagement

- All patients were asked to complete a satisfaction survey about their experience at the hospital. The hospital reviewed the responses from patients and produced a report every three months. We reviewed the reports from October 2015 and March 2016. Both reports indicated that that feedback from patients was positive. There were no areas identified as requiring improvement and the reports showed that 98% of patients indicated they would recommend the hospital to family and friends.
- Whilst the hospital did seek feedback from patients regarding their care, they did not perform quality measurements such as collect Q-PROMS information from patients as recommended by the Royal College of Surgeons (RCS)

Innovation, improvement and sustainability

- The registered manager had recently applied to become a member of the Association of Independent Healthcare Organisations to assist in benchmarking services.

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 18 HSCA (RA) Regulations 2014 Staffing All doctors did not have an up to date appraisal which is necessary to enable them to carry out the duties they are employed to perform. Not all staff could recall the last supervision they had received and we were told that a manager had not supervised staff appropriately or checked on their practiceThese are necessary for to make sure competence is maintained.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Records were not always kept securely so that they were only accessed by people who were authorised to do so. The provider was not actively encouraging feedback about the quality of care and overall involvement of patients through the use of national tools such as Q-PROMS.and SNOMED information. The adverse incident management policy and procedures did not reflect the duty of candour requirements, which came into force in April 2015. This ensures that the provider acts in an open and transparent way with relevant persons in relation to care and treatment provided.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not fully assess, monitor the quality and safety of service provided** **The provider did not fully assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others** **The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user** **The provider did not fully evaluate and improve practice in respect of the processing of information**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not always being provided in a safe way for service users. This included doing all that is reasonably practicable to mitigate risks, ensuring that care and treatment provided is done by persons who have the competence to do so safely and the proper and safe management of medicines.** **The provider did not ensure that relevant information was directly shared in line with current legislation and guidance**