Clifton Lane Clinic

Quality Report

Clifton Lane
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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

Overall summary

Clifton Lane Clinic is operated by Clifton Lane Clinic Ltd. The hospital specialised in cosmetic surgery procedures. Facilities included; one ward, one operating theatre and outpatient and diagnostic facilities.

After an unannounced responsive inspection carried out in March 2017, the provider was issued with a warning notice in regard to Regulation 17: good governance. We also issued requirement notices in regard to compliance with Regulation 12: staffing, particularly regarding in theatres and Regulation 15: environment, particularly in relation to the operating theatre. We carried out this focussed follow up inspection on 19 July 2017 in order to ensure the provider had taken action to comply with the regulations. At this inspection, we found there had been improvements made; however, there was still more work to do in some areas.

We found the following improvements had been made:

- Hospital wide governance, medical advisory committee and staff meetings took place at regular intervals.
- There was a formal risk register in place.
- The theatre environment was clean and there were no environmental risks. New equipment had been ordered.
- The controlled drug record book was completed appropriately, audits carried out and no discrepancies were seen.
- New staff had been appointed on the ward and in theatres.

We found the following areas where the provider still needed to improve:

- There were still some improvements that needed to be made to the investigation of incidents and to ensure learning took place.
- There was no evidence of regular review of the risk register or discussion of risk at governance meetings.
- Audits needed to be more robust, with appropriate accompanying action plans that were regularly monitored and reviewed.

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. Although there had been improvements in governance, for example, the introduction of a risk register and regular governance meetings scheduled, there were still issues remaining about the systems and processes in place. We therefore issued the provider with a requirement notice concerning good governance to ensure effective systems and processes were in place for investigating and learning from incidents and to improve the safety and quality of the service.

Ellen Armistead

Summary of findings

Deputy Chief Inspector of Hospitals (North)

Summary of findings

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Summary of this inspection

Background to Clifton Lane Clinic

Clifton Lane Clinic is operated by Clifton Lane Clinic Ltd. The hospital was registered with CQC in December 2013. It is a private hospital in Rotherham, South Yorkshire. The hospital formed part of a wider clinical group that provided cosmetic surgery services for patients in the North West and Yorkshire (New Birkdale Clinic). The hospital is registered with the CQC to provide surgery and

diagnostic and screening procedures. The hospital has not had a registered manager in post since July 2016. A new manager had requested that they be registered by the CQC in August 2016.

The hospital consisted of an outpatient consultation area, a ward with five bedrooms and an operating theatre.

A responsive inspection carried out in March 2017 identified concerns and a warning notice was issued relating to good governance.

Our inspection team

The team that inspected the service on 19 July comprised a CQC inspection manager and a CQC inspector. During the inspection, we visited the theatre and ward areas. We spoke with the hospital manager, the ward sister and two members of theatre staff.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that there had been improvements since our last inspection:

- The theatre environment was clean and had undergone regular deep cleans.
- Entries made in the controlled drug record book were appropriate and in line with hospital policy. Regular checks were made on the controlled drugs and a recent audit had found no discrepancies.
- New labels had been produced for the take home medication; however, these still did not contain the full address of the hospital. Staff told us that they were going to start ordering ready-made take home medication, which would already be labelled.

However, we also found that:

- There was limited evidence to show that incidents were robustly investigated or that learning was effectively shared.
- There were gaps in the policy concerning the identification of critically ill patients.

Are services well-led?

We found that there had been some improvements since our last inspection:

- Governance, medical advisory committee and team meetings took place regularly.
- There was a formal risk register in place.

However, there were still areas where the service provider needed to improve:

- There did not appear to be a clear structure to governance meetings and there was no discussion of risk.
- There was no ongoing assessment or monitoring of risks identified on the risk register.

The audit process was not robust, with no action plans available.

Surgery

Safe	
Well-led	

Are surgery services safe?

Incidents

- Incidents were reported in line with hospital policy. Staff were able to tell us how they would identify and report an incident.
- The only incidents the hospital had since our last inspection were patient infections. We saw incident reports for these infections and an infection proforma had been completed for all infections with details of the patient, swabs taken and the bacteria grown.
- The ward manager was able to describe to us the action that they took following investigation of an incident. However, there was no evidence of any formal action planning or learning from these incidents. There was a lack of systems and processes to ensure effective investigation and learning from incidents.

Cleanliness, infection control and hygiene

- At our last inspection, there were visible signs of contaminants in the theatre and the operating table covering was worn. There was visible dust between the theatre ceiling tiles and on top of pipework.
- At this inspection, the theatre environment was clean and there were no visible signs of contamination.
- At the previous inspection, there were signs of rust beneath the padding on the arms of the operating table. At this inspection, we saw evidence that new arms had been ordered, but these were not yet in place.
- There was a six weekly schedule in place for theatre deep cleans. We saw evidence that these had been done on the 3 March 2017, 11 April 2017 and 15 June 2017.

Medicines

- At the previous inspection, we found discrepancies with findings identified in the hospital's controlled drug audits and what we found on inspection. We saw entries made in the controlled drug record book, which were not in accordance with hospital policy.
- At this inspection, we reviewed the controlled drug record book from March 2017 to the date of our inspection and found that it had been completed appropriately.
- We looked at the controlled drug daily checklist and found some dates when the record had not been signed to say that checks had taken place or that the theatre was not in use. We saw five days in June and seven days in July when nothing had been recorded.
- The controlled drug accountable officer had carried out a controlled drug audit on the 8th April 2017. There were no discrepancies seen.
- We saw drug fridge temperature records. A paper copy was held with the fridge, which showed that there were five days at the end of June when no record of checks had been noted. The fridge was not checked on those days when there was no theatre list. However, there was also electronic monitoring of the fridge temperature, which was used as a backup to the daily log. We saw electronic records, which showed that the fridge temperature was within range.
- Staff were aware of the process to follow if the temperature fell out of range.
- Since our last inspection, the medicine labels had been changed to include required information. However, they still did not have the full address of the clinic provided in accordance with legislation and best practice recommendations. The manager told us that they were going to start ordering pre-packed take home medicine, which would already be labelled, to avoid them having to print labels.

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

- At our last inspection, we identified gaps in the hospital policy documents concerning the transfer of critically ill patients. This policy had been amended to make it clear that it was the responsibility of the surgeon to make the handover call. However, there was still no clear assessment criteria or reference to early warning score triggers.
- We looked at the early warning score tool used on the ward, there was no clear information about when and

how patients should be escalated. The ward sister told us that if a patient was scoring five or above they would escalate to the resident medical officer (RMO) and could give us an example of when a patient had needed escalation.
- Health care assistants carried out observations and would always tell a qualified member of staff what the patient's observations were.
- We saw an early warning score audit that was carried out in May 2017. It had been identified as an outcome that staff would be given more training. However, there was no clear plan for this.
- Staff did an NHS early warning score training package online. We saw this training course and it gave examples of the observations that should be taken and when a patient should be escalated.
- The ward sister took immediate action, whilst we were on inspection, to put escalation information in the patient files. We saw that laminated escalation advice was placed in patient folders before we left.

Nursing and support staffing

- At our last inspection, the theatre staffing did not comply with Association of Perioperative Practice guidance (2014) or Perioperative Care Collaboration guidance (2012). Staff were 'doubling up' to cover surgical first assistant and scrub duties.
- Since our last inspection, the theatre manager had left. At the time of this inspection, the hospital manager had taken over the management of theatres.
- A new registered nurse had been appointed to start in September 2017, which would mean there were two registered nurses for the ward.
- A new scrub nurse had been appointed and there were scrub nurses and operating department practitioners who worked on the bank, to cover two theatre lists a week.

Are surgery services well-led?

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- At the previous inspection, we saw that there was a lack of regular medical advisory committee (MAC) and governance meetings. There was no risk register in place and we were not assured that audits were robust and captured the appropriate data.
- At this inspection, we saw minutes from a MAC meeting held in July 2017. The minutes reflected good discussion around hospital business and there had been agreement at the meeting that MAC meetings would be held every four months and governance meetings would be held every three months. The next MAC meeting was scheduled for November 2017 but there had been no exact date set, as it would be determined by staff availability nearer the time.
- We saw evidence of discussion of the outcomes of the last inspection and progress against required actions.
- We saw minutes from a clinical governance meeting held in May 2017. There did not appear to be any clear structure to the meeting and there had been no discussion of risk or evidence of learning from incidents.
- A risk register had been put in place and we saw that risks had been identified back to January 2017. Although a risk register was in place, we noted that one page did not have any columns for progress, completion dates or residual risk.
- The hospital manager told us that the risk register would be reviewed when they felt there were new risks identified to add to the register. There was therefore no ongoing assessment or monitoring of the risks identified.
- Audits were regularly carried out; however, there were no clear action plans. The hospital manager and ward sister could give us examples of their plans following audits but these were not fully documented, which would ensure the audit process was robust and ensure learning took place.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider MUST ensure that governance systems and processes are operated effectively to ensure that services are assessed and monitored and any risks mitigated.
- They must continually evaluate and seek to improve their governance and auditing practice.
- The provider must ensure there are effective systems to ensure drug fridge temperatures are reviewed daily.

Action the provider SHOULD take to improve

- The provider SHOULD ensure their transfer of critically ill patient policy includes identification of a critically ill patient.
- The provider SHOULD ensure take home medication is labelled in line with national guidance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity and 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity How the regulation was not met: · The provider did not analyse and review information. · The provider did not monitor progress against plans to improve the quality and safety of services. · The provider did not effectively monitor identified risks. · The provider did not have the systems and processes in place to ensure learning from incidents took place. · The provider did not ensure that medicine fridge temperatures were recorded daily.