Alexandra Health Care Limited

Alexandra Private Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

Alexandra Private Hospital is an independent hospital which provides cosmetic surgery to self-funding patients.

We carried out an unannounced focused inspection to follow up on concerns we found at our last inspection in February and March 2023, when we rated the cosmetic surgery core service overall as inadequate.

As a result of the March 2023 inspection the provider were imposed with the below conditions:

The provider is not to undertake any of the following regulated activities:

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

We only inspected some of the key questions of safe and well led as this is where the breaches of regulation were found from our previous inspection and the reasons behind the section 31 conditions, latest report was published in June 2023.

We did not inspect the safe and well led key questions in full; instead, we focused on the key lines of enquiry where serious concerns had been previously identified to see if improvement had been made.

We did not collate enough evidence to re -rate the service as we only looked at areas based around the conditions imposed. We inspected this service to determine if the service had made improvements and if the conditions imposed could be uplifted, allowing the service to re-open.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Inspected but not rated**	We did not re-rate this service during this inspection. • Staff had training in key skills. The service-controlled infection risk. • Managers monitored the effectiveness of the service and made sure staff were competent. • Leaders ran services using information systems. Senior staff understood the service's vision and values, and how to apply them in their work. Senior staff were committed to improving services continually.

Summary of findings

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Summary of this inspection

Background to Alexandra Private Hospital

The Alexandra Private Hospital is operated by Alexandra Health Care Limited. It is a private hospital located in Chesterfield. The hospital facilities include 21 beds which are split between 2 floors; however, the service mainly utilise the beds that are located on the first floor. There are also 2 theatres on the lower ground floor, 1 of which is mainly used by a third party for their procedures. There are also consultation rooms on the ground floor where patients receive their pre-operative consultations.

The hospital provides cosmetic surgery for self-funding patients. The hospital also offers cosmetic dental procedures. We did not inspect these services.

The service currently has 3 registered managers, 2 of which have been in this position since the service registered with the CQC in October 2010.

The Alexandra Private Hospital has been inspected by CQC 6 times since they were registered. The most recent inspection was a comprehensive inspection on 11 October 2022. Following this inspection, the service was rated inadequate overall.

The service is registered to provide the following regulated activities:

• Diagnostic and screening procedures.

• Surgical procedures.

• Treatment of disease, disorder, or injury.

At our previous inspections, we found the following breaches of regulation:

- The service must ensure they support patients to give informed consent for revision or return surgery following the original procedures. (Regulation 11 (1): Need for Consent).
- The service must ensure electrical items are safety tested and safe to use. (Regulation 15 (1c, e): Premises and equipment).
- The service must ensure governance processes are effective to enable sufficient oversight of performance, quality, and risk. (Regulation 17(1, 2): Good Governance).
- The service must ensure all patient and staff information is stored as per General Data Protection Regulations. (Regulation 17(2d): Good Governance).
- The service must ensure patients are able to access appropriate and timely clinical advice following surgical procedures. (Regulation 12 (2b, c, i): Safe Care and Treatment).
- The service must ensure they have oversight of staff training and competency levels. (Regulation 18 (2a): Staffing).
- The service must ensure they are reporting outcome measures to external agencies in line with legal requirements. (Regulation 17 (1,2a): Good Governance).

Summary of this inspection

How we carried out this inspection

We completed onsite visits to the service on 22 June 2023. The inspection team consisted of 1 CQC inspector and 1 operations manager.

On the day of inspection, there were no theatre lists running or patient appointments due to the conditions imposed on the provider's registration. However, we still visited the ward and theatres.

The last surgical procedure list had taken place on 15 February 2023; Following the February and March 2023 inspections, we requested the service take urgent action to mitigate serious risk of harm to patients. We placed an urgent condition on the registration of the location to not undertake any regulated activities from the Alexandra Private Hospital location without the prior written consent of the CQC due to the serious concerns and associated risk to patients. Due to the conditions imposed in March 2023, there were no administrative, nursing, or medical staff or patients on site when we arrived on site to inspect. However, we spoke with 2 registered managers and 1 clinical consultant.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should ensure that they continue to make improvements in line with recommendations from previous and recent areas we inspected.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Surgery

Safe	Inspected but not rated
Effective	Inspected but not rated
Well-led	Inspected but not rated

Is the service safe?

Inspected but not rated

We did not re-rate this service during this inspection.

Mandatory training

Staff were compliant with mandatory training requirements and the service monitored this. The service provided mandatory training in key skills for staff.

The mandatory training was comprehensive and met the needs of patients and staff. The Hospital adhered to the statutory training requirements of the core skills training framework. Managers monitored mandatory training and alerted staff when they needed to update their training.

Senior staff told us that once they re-open they will review training status of all staff on a monthly basis to confirm that training courses or modules for staff are completed and current, and to identify when staff were due renewal. This was an improvement from previous inspections.

We found improvement around the oversight process of mandatory training. The Hospital held certifications for completed training by all staff with a training matrix register to keep record of staff training. All clinical staff work on a flexible contract and work between Alexandra Private Hospital and the NHS. Senior staff told us that upon completion of a specific training course or module, the service automatically retained certification of all training completed via the hospital's training platforms and ensured that the training matrix was kept up to date. Certification of training completed via external training programmes was provided to the hospital by individual staff, it was contractual that staff provided this to allow them to be given a shift. For most staff, the primary external training programme were those of various NHS trusts, from which training records could be accessed and downloaded.

Compliance target for Alexandra Private Hospital was at 100%. The training status of all staff was at 100%.

Safeguarding

Staff had adequate training on how to recognise and report abuse.

We were unable to speak directly with staff during this inspection; however senior management team told us that the Alexandra Private Hospital service were providing level 2 training in both children and adults.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect people from infection. They kept equipment and the premises visibly clean.

Inspected but not rated

Surgery

During this inspection we visited the main ward on level 1 and found many improvements since the last inspection. Ward areas we visited were visibly clean and had suitable furnishings which were clean and well-maintained. We found the service had a cleaning tick box sheet for theatres and wards to guide cleaning staff. A third-party company directly employed cleaners.

We requested a copy of providers cleaning policy which covered deep cleans in terms of frequency and expectations for this task. The service provided us with a standard operating procedure, which they did not have in place during the last inspection. Records showed that deep cleans were undertaken on 2 occasions; October 2022 and January 2023 by internal staff with plans for another deep clean prior to re-opening of the service. The provider also informed us that deep cleaning will be carried out regularly and areas will be audited as part of their infection prevention and control policy.

The service had replaced and purchased new blood pressure arm cuffs, sinks within the theatre had been replaced, which was an issue during previous inspections due to stain and cleanliness concern.

We did not see staff working clinically during our inspection and therefore cannot determine if staff used appropriate hand hygiene methods.

Staff had access to personal protective equipment (PPE). This was stored in easy to access areas within the theatres.

The service had 1 surgical site infection from October 2022 to February 2023 which was identified post procedure.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had recently purchased 'I am clean stickers' to identify when equipment was clean and ready to be used. This had not yet been put in place as the service was not running.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment in accordance with local policies. We saw that all equipment, such as blood pressure monitoring equipment were tested regularly to ensure their safety and effectiveness. Resuscitation equipment was readily available in all the areas we visited. We were told that this would be observed regularly, recorded checks of this equipment would be completed to ensure it was safe and ready to use once the service was back up and running.

The service had an agreement with the local acute hospital for decontamination of surgical equipment which was reusable. During the last inspection inspectors found unwrapped equipment in a trolley in the first theatre which should be packaged in sterile packaging after decontamination. During this inspection we found no concerns.

During this inspection, we raised concerns around nurses call bell in the recovery rooms. The alarm that was in place did not call out to theatres staff but to the wards; therefore, urgent support would not attend in a timely manner if a patient was to deteriorate. However, the service had mitigated the risks by having a mobile phone in the room, we were still not assured this would seek an urgent response in an emergency. The provider contacted us the next working day and provided us with visual evidence that both recovery rooms was now fitted with an alarm that alert the wards and theatres if an emergency should ever arise.

The service had suitable facilities to meet the needs of patients' families and had enough suitable equipment to help them to safely care for patients.

Clinical waste was disposed of by a third-party company.

We found both theatres and surrounding areas, such as the clinical area and storage rooms were locked and secured with a secure coded keypad, with clear signage of restricted access when entering theatre, this demonstrated that improvements had been made since last inspection.

All patient windows on the first-floor ward were now fitted with restrictors this was an improvement from previous inspection, as patient were able to open all windows with an easy access to a balcony.

Theatre 1 was fitted with laminar flow ventilation as per Health Technical Memorandum (HTM) 03-01: 'Ventilation in healthcare premises'. This meant air flow was optimised to reduce the risk of surgical site infection.

During the last inspection, concerns were raised around storage of medical gases and lack of risk assessments associated with hazardous gas. There was no sign on the door of the room to indicate potential fire hazards despite a statement in the fire risk assessment stating signs were present in any areas containing fire hazards at the time that assessment was conducted. We saw improvements during this inspection, we saw clear signage on doors to identify areas of fire hazards including hazardous liquids on their Control of Substances Hazardous to Health (COSHH) cupboard. COSHH is the law that requires employers to control substances that are hazardous to health and includes nanomaterials. The service had recently purchased a yellow hazardous cupboard to store all COSHH substances, however the cupboard was unlocked when we arrived on site but was rectified immediately with clear signage in place.

Assessing and responding to patient risk

Staff used a nationally recognised tool to identify patient at risk of deterioration.

We were unable to fully assess this aspect of the service due to no patient contact or staff being on site, and the nature of the condition imposed. However, we reviewed the service new surgical pathway, which included risk assessments such as venous thromboembolism assessments and the National Early Warning Score (NEWS2). NEWS2 is a system for scoring the physiological measurements that are routinely recorded at the patient's bedside. Its purpose is to identify acutely ill patients, including those with sepsis. Staff worked at the local NHS trust and were fully trained in using the nationally recognised tool to identify deteriorating patients and how to escalate them appropriately. The document also included the delirium assessment tool should a patient's mental health deteriorate. This was an improvement from their previous inspection.

During the last inspection, the inspectors reviewed 3 World Health Organisation (WHO) safer surgery checklists and found they were not fully completed. We were unable to gain assurances around this during this inspection as there were no patient or staff on site. However, senior staff told us that the WHO safety checklist would be audited monthly and would ensure they remind all staff the requirement of this being completed.

It was noted from previous inspections that staff did not always follow patients up who did not return for post-operative checks. Senior staff told us during this inspection that patients were contacted through their own preferred method of communication, such as email or telephone call and asked to contact the service. We were unable to evidence or identify if this would be documented going forward as we were unable to speak or review new patient records since last inspection due to the conditions imposed on the service.

Senior staff told us that 95% of the time the hospital was rented by other providers under service level agreement (SLA). This meant that the pre-assessment and pre-consultation stage for those patients, sat with the company renting the facility, the same as their post-operative phases of care and reviews and satisfaction. For any private patients of Alexandra

Private Hospital, the patient health questionnaire was completed at the consultation phase, reviewed by the pending operating surgeon and any concerns, the provider would liaise with the patient and their GP to obtain further information. Senior staff also informed us that not all the aftercare of patients sat with them. Any patients belonging to the Alexandra Private Hospital would receive a call within 48 hours of discharge and all communications would be documented; Third party providers would follow up with their own patients. Patients were informed of their scheduled follow-up appointments, and the means of contacting the hospital in the event of any questions, concerns, or problems. Patients were also informed that attending for follow-up appointments was an essential part of their treatment and not an option to be considered but a requirement.

Since the previous inspection, the service has improved their processes around histology findings. If results indicated further investigation as per up-to-date policy entitled 'Pathology Reports Protocol'. Staff were required to record when samples were sent, and record when results were received from pathology.

Records

Records were mostly stored securely and easily available.

We were unable to review patient records during this inspection as there had been no new admissions of patients since the conditions were imposed on the service registration. However, during this inspection, we found some patient identifiable personal and sensitive information in areas within theatres and recovery rooms, which were not accessible to non-staff member, however some of this documentation was over 12 months old indicating it had been in place for a long time without being destroyed or securely stored. We raised our concerns with the senior teams, and this was rectified whilst we were on site and were securely stored.

We reviewed the service amended consent policy, that stated*: "at initial doctor/practitioner-patient consultation, treatment options are explained, and risks/benefits are documented on the consultation notes, which will later form part of the permanent case record and the patient signs to acknowledge that they have understood. When written information is supplied, the name / reference of that information must be documented in the consent form/consultation notes. It is the surgeon's/practitioner's responsibility to ensure that his/her patients are adequately consented. Following full explanation of the procedure and associated benefits, limitations and risk factors, the patient is questioned for their understanding and the consent form is signed. Every new operation requires a new process, new consultation, new stage 1 consent, new cooling off period and new pre-assessment."*

Medicines

The service used systems and processes to safely record and store medicines.

Staff stored and managed some medicines and prescribing safely. During this inspection we saw some eye drops and antibiotic in theatre that were kept on trolleys, we raised our concerns during the inspection and the issue was rectified in a matter of hours. Controlled Drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored and recorded following best practice procedures which included daily checks by two clinical staff members. The service had recently purchased a new medicine register logbook, this was to show medicines that have been dispensed, given, and wasted.

Staff managed and stored all medicines safely. We found improvements since the last inspection, we found 0 out of date medicines or out of date stock. We saw the provider had a stock checklist in place, and dates for all medicines including clinical stock were highlighted, with expiry date on every box to ensure all stock was manageable and older stock was being used first. Senior staff told us that plans were now in place to carry out monthly checks.

Inspected but not rated

Surgery

The temperatures in the clinical rooms and medicine refrigerators were recorded and monitored and we saw that medicines were stored within the recommended temperature range for safe medicine storage. Resuscitation trolleys containing emergency medicines and equipment were securely stored, but available and accessible if needed in an emergency. Checks were in place to ensure emergency medicines were available and safe to be used.

Is the service effective?

Inspected but not rated

We did not re-rate this service during this inspection.

Patient outcomes

The service had implemented ways to monitor the effectiveness of care and treatment.

During the previous inspections, the service did not submit performance data to participate in relevant national organisations that publish performance results. This was identified on our previous inspection in October 2022. From 2018, the Competition and Markets Authority required every operator of a private healthcare facility that admits patients including cosmetic surgery patients to collect performance data and to supply this to the Private Healthcare Information Network (PHIN).

The service had attempted to collect clinical quality indicator data; specifically, Q-PROMS (patient reported outcome measures) for cosmetic surgery. These are self-reported pre- and post-surgery questionnaires which seek to measure patient satisfaction on the quality of their surgery. The provider told us that all 4 patients were provided with Q-PROMs questionnaires. As of the present date, none of these patients had submitted responses. All other patients undergoing procedures covered by Q-PROMs during previous inspection period were patients of third-party providers, with their Q-PROMs data being collected by their respective providers.

Q-PROMS data collected for the following types of surgery which were undertaken at the Alexandra Private Hospital:

- BREAST-Q – Augmentation mammoplasty 2 patients
- FACE-Q – Rhinoplasty 1 patient
- FACE-Q – Blepharoplasty 1 patient

During this inspection the service had implemented a patient satisfaction tool for use in future to sit in line with outcomes and PHIN, along with mental health questionnaire for pre-admission and the senior managers were keen to begin this work as soon as they were able to re-open.

Is the service well-led?

Inspected but not rated

We did not re-rate this service during this inspection.

Leadership

Leaders understood the priorities and issues the service faced.

Inspected but not rated

Surgery

Since our previous inspection, the provider has since employed a clinical consultant to support improvements to the service provided. The provider had also employed a senior nurse to carry out audits and ensure staff were kept up to date with any improvements required.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Leaders understood and knew how to apply them and monitor progress.

Since the previous inspection, the service has reviewed and implemented their **"**mission and core vision". Their aim was to provide a "first-class independent healthcare for the community in a safe, comfortable and welcoming environment; one in which we would be happy to treat our own families".

The providers values and strategy to achieve this included:

Beyond Compliance:

- Going above and beyond to improve the business.
- Being recognised for demonstrating outstanding care.
- Being better than the rest, safer than all others.
- Committed to going the extra mile, doing more than just enough.
- No Blame: speak up when you believe it's right or wrong.

Taking time to care for others:

- Recognising that one size does not fit all, patients are individual.
- Respect patients – Treat them as an individual, uphold their dignity.
- Hear patients – Take time to listen, hear and respond, not react.
- See patients – Make them feel special, included, and welcome.
- Ask patients – Don't assume you know what they want, hear what they say.
- Acknowledge patients – for their effort, their contribution, and their guidance.

Partnership and Teamwork:

- Be positive.
- Be coordinated and collaborative.
- Be considerate towards colleagues.
- Be honest and respectful in communications.
- Be clear about goals and objectives.
- Be open minded to others' views, you will learn this way.
- Be inclusive.

Aim to be the best:

- Investing to improve.
- Investing in employees.
- Investing in yourself – Be the best you can be.
- Cultivating positive mental health.
- Investing in quality outcomes, focus on improvement.

- Investing in the future, of the business, the people, the industry.

Always with Integrity:

- Respected, admired and reliable.
- Do the right thing.
- Be fair and honest.
- Be willing to learn.
- Have courage to change.
- Speak out when you should.
- Consider the consequences of your actions.
- Be respectful to others and yourself.

Governance

Leaders operated an improved governance processes and in progress of change. Staff were clearer about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Managers were now able to provide policies and procedures which clearly outlined what mandatory training was required per staff member and how often each staff member should complete this.

The service kept an accessible record which provided quick oversight of staff training compliance. This meant managers would be able to easily track training and prompt staff when training was due.

Following on from the inspection visit in February 2023; managers have installed locks on the outer theatre area doors and clinical areas within. There was now a process in place to assess the health and safety of the building and environment.

We saw some improvements, although at early stages, an audit schedule was now in place. This was only implemented following February and March 2023 inspection, despite a warning notice being issued and enforcement action plan from concerns raised back in October 2022. In addition to the audit schedule, the service now had a process to review quality of patient records, with plan to review patient records every month to ensure all records are comprehensive and legible.

The service had a device management policy and kept a record of specialist clinical equipment and maintenance.

The service held a medical advisory committee (MAC) meeting chaired by the Medical Director. During the February and March 2023 inspection, we were not assured that these meetings were effective as a governance process to share information, drive change or monitor performance. However, during this inspection, the service had improved their agenda and their formal committee meeting minute template for their future meetings. The agenda covered topics such as MAC terms of reference / statement of intent, buddy surgeons, surgeon validation and pending issues, surgeon documentation praise and learning points, Implants and any updates or incidents, business updates, clinical update (nursing teams, policies, and staff development), Clinical governance data; infections and complaints.

Management of risk, issues, and performance

Leaders and teams used systems to manage and improve performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Inspected but not rated

Surgery

During this inspection, we found improvements from previous inspections. The service now had an up-to-date risk register. Which were RAG rated (red, amber, green) with scoring to highlight the urgent risks. We saw that out-of-date stock, incomplete or inaccurate patient records and the risk of non-compliance with legal and regulatory requirements were reported within the risk register. Senior manager told us that the risk register will now feed into the new governance meetings which would commence as soon as possible.

Managers of the service had better oversight of compliance with safety requirements during this inspection, senior teams told us they had learnt and improved since the last inspection. Service leaders had employed a clinical consultant to support and improve the services for both staff and patient and to ensure the service was compliant.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

On our visit to the service in February 2023, we found the service was not displaying their CQC rating as per Regulation 20A: Requirement as to display of performance assessments (Health and Social Care Act (2008) Regulated Activities. We informed the registered managers of this finding; this was subsequently displayed in the waiting area on our second inspection visit in March 2023. During this inspection in June 2023, we noted this was now displayed on the service's website as required by this regulation.

During the previous inspection the service did not collect data to drive improvements or understand improvements. No audits had been undertaken since our previous inspection. However, the senior teams had an audit schedule in place and would ensure to share their audit result with us once the service re-opened.

The service had submitted their latest quarterly report to CQC under the Controlled Drugs Regulations 2013 to be included in the Controlled Drugs Accountable Officer Register.

During the previous inspection the provider had ongoing external problems with the electronic server and they had started to move back to a paper-based approach. However, since then the service had rectified the issue and electronic system was now in place.