Woodford Medical Limited - The Old Forge

Quality Report

141 Main Road
Danbury
Essex
CM3 4AA
Tel: 01245 227983
Website: www.woodfordmedical.com

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Old Forge at Danbury is operated by Woodford Medical Limited. The service has no overnight beds. Facilities include three adjacent buildings on the same site known as the clinic, the cottage and the forge. The forge and the cottage are only used for treatments not within the scope of regulated activity. The cottage has two treatment rooms, one reception and one staff toilet. The Forge has two treatment rooms, one assessment room, one reception, one waiting room and one toilet area for patients. The clinic building was where all medical treatments by the doctors, surgeon and nurse are undertaken. It has two treatment rooms, one waiting room and one toilet for patients and one reception area. On the first floor there are two rooms for administration with a kitchen and toilet for staff.

The service provides cosmetic minor surgery and day attender treatments for fillers, surgical thread lifts, sclerotherapy (injection to improve spider veins on the legs), fat dissolving treatments and intense pulsed light (IPL) laser. During our inspection we inspected the procedures the service has registered with the care quality commission (CQC) which are, minor surgery, and sclerotherapy services.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 22 October 2019 and followed up with telephone calls to six patients who consented to discuss their experience with us.

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

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

The main service provided by this clinic was minor surgery which includes the removal of lumps or moles, eye lid surgery and sclerotherapy.

All non-invasive treatments were not inspected as they are outside of the regulated activity registered with the CQC.

Services we rate

We found safe, effective, caring, responsive and well led were all good. This led to a rating of good overall.

We found areas of good practice:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents. Staff monitored patient safety information.
- Staff provided good care and treatment, gave patients enough to drink, and gave them pain relief when they needed it. The manager and two clinicians monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to information. However, not all guidelines were supported by references
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.

Summary of findings

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- The two doctors ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and how to apply in their work. The service had no clear strategy currently for future development. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and all staff were committed to improving services continually.

  Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Heidi Smoult
Deputy Chief Inspector of Hospitals (Central)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital. We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

Contents

Good

Woodford Medical Limited

Services we looked at
Surgery

Summary of this inspection

Background to Woodford Medical Limited - The Old Forge

The Old Forge at Danbury was operated by Woodford Medical Limited. The service opened in 1996. It is a private service situated in Danbury, Essex. The clinic primarily serves the communities of the Essex region. It also accepts patient referrals from outside this area.

The main service provided at the clinic is minor surgery. All surgery is performed as a day case with local anaesthesia

The hospital has had a registered manager in post since 29 January 2011.

The clinic facilities were situated on ground floor level with staff facilities based on the second floor. The clinic had a reception and waiting area, consultation room, treatment rooms and minor surgery procedure room. On the first floor there was an administrative area and staff rest room.

The clinic provided day case minor surgery and aesthetic treatments. There were no patients under the age of 18 seen at the clinic for sclerotherapy or minor surgery.

The clinic offered services to self-paying or privately funded patients.

The hospital also offered cosmetic procedures such as dermal fillers and laser hair removal, rejuvenation treatments and other laser treatments which are not a regulated activity, therefore we did not inspect these procedures.

The Old Forge, at Danbury has been inspected once before, on 31 January 2014. At the last comprehensive inspection, we did not have the legal duty to rate this service and found that the service met all the requirements of the inspection.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one other CQC inspector. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about Woodford Medical Limited - The Old Forge

The Old Forge provides a range of cosmetic treatments and surgical procedures. The top three procedures completed between March 2018 to February 2019 was for Botulinum toxin injection, intense pulsed light (IPL) and laser and dermal fillers. However, we did not inspect these services as they are outside of regulated activity. The main regulated service provided by this clinic was minor surgery which included the removal of lumps or moles, eyelid and eye bag surgery and sclerotherapy.

The clinic is registered to provide the following regulated activities:

- Surgical procedures
- Treatment of disease, disorder or injury

During the inspection, we visited all areas of the clinic including the procedure and treatment rooms. We spoke with six staff including; reception staff, medical staff, therapy practitioners, and senior managers. We spoke with one patient on site and following our inspection we telephoned five patients, who consented to speak to us. During our inspection, we reviewed four sets of patient records. We were unable to observe any surgical procedures as no patients were booked to attend on the day of inspection.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12

Summary of this inspection

months before this inspection. The service has been inspected once before in January 2014, we found that the service was meeting all standards of quality and safety it was inspected against.

Activity (March 2018 to February 2019)

- In the reporting period March 2018 to February 2019 There were 3,986 episodes of care recorded at the service; of these 100% were privately funded.
- There were 3,727 first attendances and 259 follow up appointments.
- The service reported 72 sclerotherapy procedures and 52 minor surgery cases which were within the regulated activities.
- There were 98% patients seen that were between the ages of 18 and 74 years and 2% were above 75 years of age.

At the time of the inspection there were two doctors who undertook minor surgical procedures, one ophthalmic surgeon who performed minor surgery and eyelid surgery. There was one registered nurse who performed sclerotherapy, two clinical assistants who supported doctors, two marketing staff, three therapists and three receptionists. The provider did not store controlled drugs (CDs) at the premises and therefore there was no medications accountable officer.

Track record on safety

- Zero never events
- Zero clinical incidents during the reporting period
- Zero serious injuries
- Zero incidences of healthcare acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of healthcare acquired Meticillin-sensitive Staphylococcus aureus (MSSA)
- Zero incidences of healthcare acquired Clostridium difficile (C.difficile)
- Zero incidences of healthcare acquired Escherichia coli (E-coli)
- Zero complaints

Services accredited by a national body:

- None

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Laser protection service
- Laundry
- Maintenance of medical equipment
- Pathology and histology

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The main service provided by this clinic was minor surgery and cosmetic treatments.

Are surgery services safe?

Good

This is the first time we have rated this service. We rated it as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. All staff had received mandatory training in safety systems, processes and practices. Mandatory training included: infection control, information governance, adult basic life support and fire safety. Most training was provided via e-learning and we observed training certificates awarded to staff. Additional face to face sessions were delivered, for example, basic life support training and fire safety. Staff within the service understood their responsibility to complete mandatory training.

The service had a registered nurse and a surgeon who worked when they were needed by the service, we saw their completed mandatory training certificates and the electronic training records.

The mandatory training was comprehensive and met the needs of patients and staff. All staff had completed paediatric immediate life support and basic life support training.

The manager monitored mandatory training each month and alerted staff when they needed to update their training. This assured us that there were effective governance processes in place to confirm staff were up to date with mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

There were processes in place to safeguard adults and children from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service's safeguarding policy was within date and accessible to staff who could access it through the electronic system. The policy referred to adults and children and included a clear process for staff to follow with contact details for escalation of concerns outside of the service. The service did not treat children but had a policy as children attended with parents or carers during treatment.

Safeguarding training completion rates

All staff received training specific for their role on how to recognise and report abuse. Safeguarding training was provided by e-learning and face to face sessions which staff accessed and were given protected time to complete.

A breakdown of compliance for safeguarding training courses up to October 2019 showed that eight staff out of 12 (67%) had completed safeguarding for vulnerable adults level one, two staff (17%) who had completed safeguarding for children level two and both medical staff and one other staff member (25%) had completed safeguarding for vulnerable adults at level three.

Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them.

There had been no safeguarding concerns raised in the reporting period from March 2018 to February 2019.

The service had an up to date chaperone policy and notices were displayed within the clinic area that advised patients that a chaperone was available on request.

Staff had Disclosure and Barring Service (DBS) checks and employment checks when they commenced employment within this service. DBS checks help employers make safer recruitment decisions. DBS checks were included as part of this service's practising privileges local guidance. The manager showed us that all staff had Disclosure and Barring Service (DBS) checks carried out at the appropriate level for their role. These DBS forms were monitored throughout their employment and kept within staff paper records which were kept within a locked cabinet.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained, with cleaning schedules in place which were completed twice weekly by the cleaner who attended the service each Wednesday and Saturday. The treatment room and procedure area were cleaned between each patient by staff. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff used records to identify how well the service prevented infections, with all pre-treatment risk assessment included with the patient history for Meticillin-resistant Staphylococcus aureus (MRSA). There were no incidents of MRSA for the reporting period from March 2018 to February 2019.

The service used single patient use instruments. The decontamination of equipment was outsourced to another service for equipment that was not single use.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service had an up to date infection prevention and control policy. We observed that there were hand hygiene notices across the service. All staff were bare below the elbows. We observed evidence of PPE which included gloves and sanitising hand gel. Hand hygiene audits were completed monthly and showed consistent compliance outcomes above 98% between January 2019 and October 2019. .

Patients were provided with written information about pre-operative skin preparation before their treatment as well as post treatment care requirements to promote healing.

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 suitable facilities to meet the needs of patients' families. The premises were maintained with suitable facilities for the minor surgery procedures and consultations. The service had stopped blepharoplasty (eyelid and swelling under the eye) surgical procedures from August 2019, after the service assessed the procedure room was not in line with national requirements (Department of Health (DH) Health Building Note 00-10 Part A: Flooring (2013)). The procedure room was being upgraded to ensure the area met guidance requirements before blepharoplasty procedures restarted. The manager confirmed risk assessments were completed to support the minor surgery procedure rooms upgrade.

The service had enough suitable equipment to help them to safely care for patients.

All equipment had visible dated labels that showed they were recently tested. We reviewed the equipment maintenance list which showed all equipment had been checked within the past year. Staff mostly carried out

monthly safety checks of specialist equipment. The resuscitation equipment was checked monthly and equipment was within the expiry date, although we saw no completed checks for August 2019 when we reviewed completed checks between June to October 2019.

There was a service level agreement in place with an external company for the collection of waste. This ensured the safe collection, handling and disposal of all clinical waste.

We found the Control of Substances Hazardous to Health (COSHH) products stored appropriately and was included on the risk assessment for COSHH products. The COSHH regulations required employers to control exposure to hazardous substances to prevent ill health.

Staff disposed of clinical waste safely. Sharps bins were labelled and used appropriately with no overfilled sharps' bins seen in the clinic.

Toilet facilities were available for patients next to the reception area. However, there was no call bell system for patients who required assistance after a procedure. Staff were observed within close proximity to the area to respond to a patient if they needed to call for assistance.

Fire safety equipment was fit for purpose and in date. This included fire extinguishers, alarm system and emergency lighting.

A practice fire drill had taken place in January 2019 with records of those staff who attended.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff completed risk assessments for each patient on arrival and used an appropriate risk assessment tool, to identify their health and wellbeing and reviewed this regularly, including after any incident.

Pre- operative consultations were carried out in line with national guidance. Risk assessments included the patient's suitability for the procedure, which included, medical history, general health, age, existing health concerns, medications and other procedures. Psychologically vulnerable patients were identified and referred for appropriate psychological assessment in line with the Royal College of Surgeons Professional Standards for Cosmetic Surgery (2016). Following the pre-operative consultation, if the patient consented to the procedure and met the criteria the service contacted their general practitioner regarding planned procedure to ask if there were any contraindications.

Staff knew about and dealt with any specific risk issues.

All patients treated at the clinic had undergone a pre-operative consultation and assessment and had access to a clinician's telephone number, in case they needed to contact them for follow up advice or further treatment.

Patients who attended the clinic underwent procedures under local anaesthetic. This meant patients did not require routine screening for risk of venous thromboembolism **(**VTE) because there was a very low risk of acquiring a VTE while having treatment.

Patients seen at the clinic were screened to assure the service that they were fit and healthy to have the procedure. Staff reduced the risk of complications, the clinicians completed detailed patient past and current medical history records. Staff were aware of the signs and symptoms of sepsis. If they suspected a patient had sepsis they would arrange for immediate transfer to the local acute NHS trust. There was no evidence of any patients being transferred for sepsis or any complication in this way since the service opened.

Staff shared key information to keep patients safe when handing over their care to others.

All patients were told to call the clinic if they had any concerns post procedure If a patient had a concern that was not urgent they were given an appointment slot at the next available clinic. Patients could contact the service out of hours and all patients we spoke with, spoke highly of the support from the service.

The clinic only carried out minor cosmetic procedures that could be performed under local anaesthesia. The resuscitation policy included details about what action should be taken if a patient deteriorated. Staff were able to describe what they would do if a patient required immediate transfer, which involved dialling 999 and requesting an ambulance transfer to the local urgent and emergency services.

Good

Surgery

We saw that all staff had completed training for basic life support, the service's resuscitation policy included the escalation process and pathway to treat patients with anaphylactic shock (an extreme, often life-threatening allergic reaction).

Staff told us if this was to happen they would accompany the patient until they had safely reached the hospital and handed over their care. No patients treated at the clinic had required a transfer between this service and the local acute NHS provider.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Managers regularly reviewed and adjusted staffing levels and had an induction staff handbook for bank and agency staff, the staff handbook was given to all staff as part of their induction. All staff had an initial induction to the service which included the staff handbook with policies and procedures. Staff were provided with some specific clinical training for their role in addition to mandatory training.

The surgeon had an induction programme to work within the service and we reviewed completed practising privileges documentation which were kept electronically and as hard copies.

There was no nurse and allied health staff vacancies at the time of the inspection. The service employed staff who worked set hours each week and four therapists who provided non regulated treatments.

No procedures had been cancelled due to inadequate staffing from March 2018 to September 2019, the service reported no bank or agency staff were used during the same time period.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. We reviewed four patient records that were fully completed as paper and electronic documentation. All documentation entries reviewed were dated, with staff signatures on each page. We observed staff documented procedures and conversations, and updated paper records for each patient.

There were no delays in staff accessing the patient's records. Access to electronic records was protected with staff having individualised password protected log-ins. We observed that information technology systems were locked when not in use.

Paper records were stored securely, in locked filing cabinets within the administration office. Pre-operative assessments were recorded and stored in the patient's record. They included the patient's next of kin and general practitioner (GP) details, past medical history, allergies, medications and any actions to take before the procedure.

Patients were given a discharge summary letter and details of the procedure completed, with the appropriate post treatment advice, with contact numbers and any follow up appointments. All patients were advised to give a copy of the letter to their GP.

Patient records included tracking details which identified patients who had been treated with a particular device or medication, so that in the event of a product safety concern or regulatory enquiry those patients could be easily identified. This was in line with national guidance Royal College of Surgeons Professional Standards for Cosmetic Surgery (April 2016).

The manager completed monthly record keeping audits. We reviewed the audits which contained details of the number of records audited, if omissions were found and clear action plans to improve performance if needed. The audit results between January 2018 and December 2018 showed 99% compliance against the set target of 95%.

Medicines

The service mostly used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Patients were given a private prescription for any medicines they required postoperatively.

Staff stored and managed most medicines and prescribing documents in line with the provider's policy. Most medicines were stored in locked cupboards in the procedure room. When clinical staff were on site, they were responsible for the safe custody of the medicine keys. The manager also had access to these keys. No controlled drugs (medicines subject to additional security measures) were kept on the premises.

We checked a range of medicines, all of which were within the use by date.

Medicines requiring refrigeration were stored appropriately in a locked fridge. The fridge temperature was checked and recorded to ensure medicines were stored within the correct temperature range and were safe for patient use. The fridge checklist we reviewed showed that staff had missed 70% of checks from June 2019 to October 2019. Staff understood the procedures to follow if the fridge temperature was out of range. When recorded we observed fridge temperatures were within the recommended range. The ambient room temperature where medicines were stored was not monitored. There is no national requirement to monitor this temperature, but it is considered best practice. We were not assured that medication checks were in line with the medication management policy.

Staff followed current national practice to check patients had the correct medicines, with monthly audits completed that showed all prescription records were completed correctly, kept securely and included patient allergies were clearly documented.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff told us that all medicines given to patients during their procedure were explained before they were administered, including the potential side-effects. Patients were given advice about the medicines they had been prescribed for use at home.

Staff knew about the up-to-date medicines management policy, which included the arrangements for the ordering, receiving, storage and prescribing of medicines.

Emergency medicines were kept in the resuscitation unlocked cupboard, in case a patient had an allergic reaction. This was not in line with national guidance Resuscitation Council (UK) Statement: Keeping resuscitation drugs locked away (November 2016). This was discussed with the manager who confirmed a new lockable cupboard had been purchased. All medicines were kept in the minor surgery/procedure area which could not be accessed by patients.

The service ordered medicines from a pharmacy provider as and when required.

Incidents

Staff knew how to recognise and report incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The clinic had an incident reporting policy in place which staff could easily access.

There were arrangements in place for reviewing and investigating safety and safeguarding incidents and events when things went wrong. A paper accident/incident book was used to record all incidents or accidents that occurred within the service, which all staff were familiar with. The form included patient details, the date, time and description of the incident or accident, who it was reported to, action taken by staff and changes to practice. We reviewed the incident book which showed zero incidents had been reported from March 2018 to February 2019.

Staff informed us that patients who used the service were told when something went wrong, given an apology and informed of any actions taken as a result. Staff were aware of their responsibilities with regards to the duty of candour. Staff training was available for duty of candour through e-learning with staff training evidence of compliance requested during the inspection but not yet received.

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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were no incidents reported to meet the threshold for the duty of candour.

Never Events

Good

Surgery

The service had no never events during the period from March 2018 to February 2019 and the manager confirmed there was no never events from February 2019 to October 2019.

Never events are serious patient safety incidents that are entirely preventable but have the potential to cause serious patient harm or death.

Safety Thermometer (or equivalent)

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service monitored patient safety information such as infection rates and patient outcome complications. For the reporting period there were no infections or unexpected patient outcomes that required unplanned transfers. The clinic reported zero incidents of hospital-acquired venous thromboembolism (VTE) (a deep vein blood clot) or pulmonary embolism (PE) (a blood clot in the lungs).

Patients who attended the service underwent minor procedures or treatments which meant there was a very low risk of patients acquiring a pressure ulcer, VTE or PE while having treatment.

Are surgery services effective?

Good

This is the first time we have rated this service. We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment which was mostly based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance, not all policies were referenced so we could not be sure that staff had access to the most up to date information, for example the disabilities policy.

Policies could be accessed by all staff through the service's website pages and in the policy folder held within the location. There was no separate deteriorating patient policy but the pathway for the care of the deteriorating patient was included within the updated resuscitation policy.

The service did not use the national early warning score (NEWS2) and staff explained how a detailed medical pre-assessment was completed on all patients to ensure any patient complex long term conditions were identified. The patient's suitability for treatment was holistically assessed. The staff who assessed the patient considered the past medical history, general health, mental health concerns, and history of previous surgery before any treatment was performed. The expected outcome was identified and discussed with each patient before treatment and was reviewed postoperatively. This was in line with professional standards Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery (April 2016).

Women of childbearing potential were asked for the date of their last menstruation period to ensure that treatment was appropriately given. Staff completed pregnancy tests when indicated with the patient's consent. This was in line with national guidance National Institute for Health and Care Excellence (NICE) NICE guideline [NG45]: Routine preoperative tests for elective surgery (April 2016).

From patient records we reviewed we found this service was managed in line with professional and expert guidance Royal College of Surgeons (RCS)Professional Standards for Cosmetic Surgery(April 2016). The provider had a programme of clinical and internal audit in place to monitor consistency of practice. These included; perioperative documentation, record keeping, treatments and types of surgery conducted. We observed that the detail included within the audits demonstrated for example, the sample size of the audit, the number of records reviewed monthly per clinician and if the records reviewed included entries with signatures and dates. We were assured that learning from audits were identified and implemented.

Nutrition and hydration

Staff gave patients enough drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to drink including those with specialist hydration needs identified during the initial assessment. Patients were offered drinks and a cold water dispenser was available within the waiting area.

Patients waiting to have surgery were not left nil by mouth for long periods, as all minor surgery was completed under local anaesthetic so pre-operative fasting was not required. Patients were monitored for nausea and vomiting during and following procedures. All patients were asked about any allergies which included lifestyle choices, for example vegans.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain and gave pain relief in line with individual needs and best practice, minor surgical procedures carried out at the clinic were performed under local anaesthesia. No patients were given general anaesthesia or conscious sedation. Patients we spoke with did not raise any concerns about pain when asked.

Patients received pain relief soon after requesting it, staff asked patients about any pain they experienced during, after the procedure and until the patient was discharged and managed it well. All patients we spoke with confirmed they had a good experience during and after their procedures.

Staff prescribed, administered and recorded pain relief accurately. Patients were advised to avoid aspirin after treatments, as it increased the risk of a bleeding and to obtain an alternative pain relief medication to prevent further complications following procedures. Each patient had a telephone call from the clinic after their procedure to check their well-being and assess if they were in any pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The service did not participate in any national audits to review patient outcomes but we reviewed the clinic's patient survey which compared results to the national benchmark. The results for this service in March 2019 showed 96% of patients confirmed the overall experience at the clinic was very good or good, which was above the national benchmark of 95%.

Managers told us the patient related outcomes measures data standards were collected and discussed at monthly clinical meetings in line with Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery (April 2016). Patients' outcomes were routinely collected and monitored. Detailed questionnaires were sent to patients following consultation, surgery, one-week post-surgery and at their follow-up appointment. For example, the one-week post-surgery questionnaire asked patients to rate their experience as excellent, very good, good, fair or poor against 57 measures. These included but not limited to; the quality of explanation for procedure outcome, cleanliness, effectiveness of pain control, quality of care given prior to discharge, follow-up care by the clinic nurse, and overall satisfaction with surgical outcome. Patients were also asked for any improvement suggestions and if they would recommend the clinic to a friend. This data was collated and reported annually.

All patients were offered consultation appointments prior to treatments and to make a final decision whether to proceed to treatment or surgery procedures. This ensured that the patient had sufficient time to prepare and had been given the appropriate information before a final decision was made to proceed. All patients received aftercare from staff to ensure they were satisfied with their outcome, if not, discussions were held with staff about any potential further treatment required with the patient's agreement.

Managers and staff used the results to improve patients' outcomes.

Managers told us they did not refer to the private healthcare information network (PHIN) to compare

outcomes with other providers. PHIN is an option of choice for the service not a requirement. PHIN publishes data for 11 performance measures at both service and consultant level. These measures included the volume of procedures undertaken, infection rates, readmission rates and revision surgery rates. We saw that the service did collect data on the PHIN performance measures applicable to them, such as the number of procedures undertaken, infection, readmission and revision rates.

In March 2019, results showed the intended outcomes for people were being achieved, with most patients rating their experience as very good or good. We were told that if any concerns or negative feedback was received, this was reviewed, and changes were made to improve where indicated, for example, the sclerotherapy patient leaflet was updated following patient feedback and now included the benefits and risks with the procedure.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All staff had evidence of continued learning and were supported to maintain and develop their competencies. The medical staff followed professional guidance and were mentored by an external independent practitioner to meet the requirements of their professional revalidation. The doctors were not on the General Medical Council (GMC) Specialist Register. There was evidence of current GMC revalidation and appraisal. We reviewed evidence that they participated in continued professional development activities.

The surgeon who completed the blepharoplasty (eye-lid and eye-bag surgery) was not employed by the service but used its facilities and we reviewed practicing privileges completed for this activity at the service.

Managers gave all new staff a full induction tailored to their role before they started work, this included a staff handbook, protected time to shadow staff and complete training sessions. We reviewed information that showed staff completion for training attendance.

A registered nurse who had completed further training provided sclerotherapy treatments (an injection technique for the removal and improvement of spider veins on the legs).

Managers told us that staff had completed competency assessments appropriate to the requirements of the service and we saw they were included within the staff electronic records we reviewed.

Staff had the qualifications, skills and experience required to carry out their role. The service had a process in place to check that the staff employed were professionally registered and had revalidated with the appropriate professional council and did not have any interim conditions or suspensions on their registration.

The reception staff were given additional training to support the delivery of safe and effective care, which included chaperone training and basic life support training.

There was an up-to-date policy in place for the granting and reviewing of practising privileges. The documents required before practising privileges were granted included evidence of private medical insurance cover, immunisation status, appraisal records, Disclosure and Barring Service (DBS) check, and references. At the time of our inspection, only the surgeon had practising privileges at the clinic.

We reviewed evidence that all staff had the appropriate medical indemnity insurance cover provided by the service.

The surgeon held the Royal College of Surgeons (RCS) cosmetic surgery certification. This is a voluntary certification scheme developed in response to the Keogh Review (2013), which highlighted an urgent need for the robust regulation of cosmetic practice. The scheme provided recognition to surgeons who have the appropriate training, qualifications and experience to perform cosmetic surgery, and provides assurance to patients.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

From March 2018 to February 2019 the service reported 98% of all staff in the service had received an appraisal.

Managers supported the learning and development needs of staff, we reviewed bespoke training certificates and electronic training records, for example dermatology training attendance.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The manager showed us communication sheets for staff and explained if they were not present at the meeting or at work during any change, email communication was sent to all staff which described the changes.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge, we reviewed the staff handbook which included staff support for training and was included within the individual appraisal reviews.

Managers made sure staff received any specialist training for their role, for example, we were informed about the nurse who had completed additional training to complete sclerotherapy which had been supported by the doctors.

The doctors were skilled, competent and experienced to perform the treatments and procedures they performed at the clinic, we reviewed training records and observed the numbers of patients that attended this service.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

The team worked well together to provide care and treatment delivered to patients. Staff told us they worked closely together to ensure patients received individualised person-centred care and support. All team members were aware of who had overall responsibility for each patient's care.

Relevant information was shared between the clinic and the patient's general practitioner (GP), if patients consented, the service wrote to their GP following the consultation. They informed them of the planned procedure and asked whether there were any contraindications in care. A discharge summary was given to the patient to give to their GP postoperatively. This included details of the surgery or treatment performed.

The service involved mental health services and/or psychologist support when indicated and had links with local services through local GPs and hospital services.

Seven-day services

Key services were available six days a week to support timely patient care.

The clinic was open six days a week. Monday, Tuesday and Thursday from 9am to 7pm, Wednesday and Friday from 9am to 6pm, and Saturday 9am to 1pm.

The clinic only undertook planned procedures, with patient lists organised in advance.

The doctors gave patients their personal mobile number and told patients to call that number or the clinic telephone number if they had any concerns. If their call was not answered immediately and they were concerned, they were advised to contact their local GP,111 the number used to call when advice or medical treatment is required quickly when it is not an emergency before contacting their local accident and emergency department.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and available support. The smoking status and alcohol intake of patients was recorded at the initial patient consultation. We reviewed the written information available for patients on the potential risks and side-effects for those patients who smoked or drank alcohol prior to and after surgery. This was to reduce the risk of any complications and help promote healing.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients were supported to be as fit as possible for surgery. For example, patients were advised to stop, or at least reduce, smoking and alcohol intake before and following surgery. They were also told they could eat and drink as normal before their procedure, which was in line with national guidance.

Consent, Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Good

Surgery

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The medical director told us they had not had any patients at the clinic who lacked capacity, request their services. If they had any concerns about a patient's capacity to consent, they would not perform treatments or surgery without involvement from the patient's GP and a psychologist.

Staff made sure patients consented to treatment based on all the information available. Staff understood their responsibilities regarding consent. The doctors offered patients consultations before they carried out any treatments and explained the expected outcomes and ensured the patient understood these and any potential risks before agreeing to go ahead with procedures or surgery.

Staff clearly recorded consent in the patients' records. We saw detailed preoperative information, which included managing expectations, risks and potential complications. This was supported with photographs of what to expect postoperatively. Consent was obtained in line with national standards Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery (April 2016). Consent was obtained in a two-stage process. Most patients undergoing surgery waited a minimum of two weeks between consultation and surgery. Information on the procedure was given at a different time to the signing of the consent form. Written consent was formally taken on the day of surgery. Consent was always taken by the operating surgeon or doctor.

The manager told us if they felt a patient's expectations were unrealistic they would refer them to back to their GP or a psychologist before carrying out the procedure.

Patients we spoke we confirmed they were told they could change their mind at any point.

We reviewed four patient records and found consent forms were fully completed, signed and dated by the patient and the clinician. The consent forms were comprehensive and included details of the planned procedure, intended benefits, potential risks and complications.

The clinic had an up-to-date policy regarding consent, which included a section on capacity to consent.

Records showed that staff gained verbal consent before undertaking any treatments of care.

Patients under the age of 18 were not treated at the clinic. We reviewed the patient register, which contained details of all surgeries performed in the clinic and no patients under the age of 18 had surgery.

Mental Capacity Act training completion

Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005. Managers told us that no patients were seen at the service who lacked capacity. If there were any concerns about a patient's capacity to consent, they would seek further information from the GP with the patient's consent but they would not proceed with any treatments.

Staff understood their responsibilities around consent and we reviewed patient records that included documentation about expected outcomes, potential risks and confirmed that the patient understood before starting any treatment or procedure. We reviewed detailed preoperative information which included expectations, risks and potential complications.

Are surgery services caring?

Good

This is the first time we have rated this service. We rated it as **good.**

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

There was no clinical activity on the day we inspected so we spoke to six patients who consented to speak to us following our inspection. All these patients had attended the service in the last year. They told us; the care they received was professional, they felt well informed and would not go anywhere else. Several patients described how they travelled from other parts of the country to attend this service.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. The service had a person centred culture. Staff were motivated and inspired to provide care that was kind and promoted patient's dignity.

Patients said staff treated them well and with kindness, that staff were professional ,respectful and considerate. Staff introduced themselves and informed patients about their role and responsibilities.

Patients told us they were fully involved in decisions about their care and were able to ask questions.

Staff followed policy to keep patient care and treatment confidential. Patient's told us their privacy and dignity were understood and protected.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Appropriate facilities were available for patients to undress where required and gowns were provided where necessary.

There was a up to date chaperone policy and a notice for patients to ask for a chaperone if required.

Feedback from the patient satisfaction survey March 2019 showed that all of the responses completed were positive about the care they received.

Several patients who spoke to us said they had recommended this service to a family member who had also been pleased with the service.

Patients gave the service thank you cards with positive feedback which were displayed in the clinic and included compliments for individual staff members.

Patient feedback about this service was available on an independent social media site and all comments were positive about the service and the care provided by the team.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. One patient said all the staff are always available to help and gave them time to discuss their concerns and to listen, for example, "As a nervous patient who chickened out of the procedure a few times I was met with understanding and kindness each time".

Staff supported patients who became distressed, by helping them maintain their privacy and dignity. We were shown that at the back of the building there was an exit that was not overlooked, which meant patients did not have to go back through the waiting room to exit the service after treatment if they chose.

Patients were given appropriate and timely support and information. Patients we spoke with said that staff took the time to reassure them. One patient told us; "I never felt rushed"'

Staff undertook training on having difficult conversations. Patients we spoke with told us, there were appropriate and sensitive discussions about the cost of treatment. Patients were advised of the cost of their planned treatment at the booking stage. This information was also sent by email, so that patients were fully aware of their planned treatment costs.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

The team had links with a psychologist who they could refer patients to, if they had any concerns about their emotional wellbeing.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients told us they had time to consider their treatment and that the risks and benefits were clearly explained. Patients were advised about the cost of any planned treatments at the booking stage. The information was also sent to patients by email.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We reviewed patient feedback from the independent patient satisfaction survey that was completed in March

Good

Surgery

2019. Patients stated that they felt involved in their care and had received the information they needed to understand their options of treatments. Patients feedback included positive comments about the time given to discuss the risks and benefits of treatments.

Patients gave positive feedback about the service. The service only performed minor surgery with local anaesthetic and other non-regulated treatments. This meant patients were independent and supported to manage their own health soon after surgery.

Are surgery services responsive?

Good

This is the first time we have rated this service. We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. The service provided a wide range of treatments for patients to access that were not all within the scope of CQC registration and inspection methodology.

Facilities and premises were appropriate for the services being delivered.

The service was located near to the village centre with limited car parking at the back of the building, however there was additional available parking across the road from the service. There was restricted access available for wheel chair users. Managers told us that they stopped surgery for blepharoplasty from August 2019 after discussions and that they are currently updating the treatment area to meet the national requirements Department of Health (DH) Health Building Note 00-10 Part A: Flooring (2013).

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Managers told us they could access translation services for patients whose first language was not English. Staff explained to us that they would ensure that patients could understand them when explaining the treatments during the initial comprehensive history taking.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed and staff spoken with were aware of this service .

All leaflets were written in English, but staff confirmed they could be translated if requested.

All patients who attended were assessed for suitability for day surgery procedures or treatments.

There were no facilities available for patients who were hard of hearing, for example loop system.

Access and flow

People could access the service when they needed it and received the right care promptly.

Patients told us they had a timely access to consultations, treatment and after care support. Most patients were seen within ten working days of initial enquiry, at a time suitable to their own lifestyle. There was a recognised two week "cooling off" period which was in line with national recommendations from the Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery (April 2016).

Managers and staff worked to make sure patients did not stay longer than they needed to, the appointment system was easy to use and supported people when attending planned appointments and ensured they had the correct time slot to discuss procedures. Patients could arrange an appointment by phone or make an enquiry via the clinic's website. Patients told us about the on-line enquiry consultation form which was easy to use and included an additional box for the patient's preference of contact and timeslot.

Patients accessed care and treatment at a time that suited them. Evening and weekend appointments were available, which facilitated flexibility and promoted patient choice. The clinic was open on Saturdays from 9am to 1pm. Weekday appointments were available for three days up to 7pm.

Appointments and treatments were only cancelled or delayed when necessary. If surgery had to be cancelled or

delayed, this was explained to the patient and they were supported to access treatment again as soon as possible. The only cancelled appointments in this reporting period were the cancelled blepharoplasty procedures which were not available at this clinic at the time of our inspection. The doctors had reviewed the minor surgery room which was being upgraded to ensure the area met guidance requirements (Department of Health (DH) Health Building Note 00-10 Part A: Flooring (2013)) before blepharoplasty procedures restarted.

The six patients we spoke with said they had timely access to treatment and reported no delays with treatments.

Technology was used to support timely access to care and treatment and to facilitate patient choice, for example, on line consultation patient enquiry forms.

Waiting times from consultations to procedures were reviewed by the manager within the patient feedback questionnaire, which was reviewed monthly and showed that patients were happy with the waiting time. The six patients we spoke with told us they had a no problem with waiting times and had arranged appointments around their own work or life commitments.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Summary of complaints

Patients, relatives and carers knew how to complain or raise concerns.

The service displayed information about how to raise a concern in patient areas, although we saw no patient information leaflets in the waiting area. We saw patient instructions displayed on how to raise a complaint in the waiting room.

Staff understood the policy on complaints and knew how to handle them. The complaints policy had recently been reviewed and was included in the induction handbook for all staff to read. The complaints policy included information about how the complaint could be raised through the manager. Staff confirmed they did try and resolve any concern at the time it was raised with them.

Managers investigated complaints and identified themes, we reviewed complaints investigated outside of this reporting period which were detailed and had comprehensive and timely responses. From March 2018 to October 2019 the service had received no complaints.

The manager was responsible for managing the complaints process. Complaints could be made to any member of staff or the medical staff either verbally or in writing. Managers sent a written response to a complaint, once a full review had been completed within 20 days.

The service kept a record of complaints received and complaints received outside of the reporting time frame had appropriate documentation with supporting evidence of timely responses.

All six patients we spoke with knew how to make a complaint or raise concerns.

In the same reporting period there were no complaints referred to the Independent Health Complaints Advocacy which is a free, independent advocacy service.

Are surgery services well-led?

Good

This is the first time we have rated this service. We rated it as **good.**

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The management team consisted of the two doctors and the manager. The doctors were the owners, and one had been the named registered manager with the care quality commission since January 2011. Both doctors were responsible for and led on clinical care and service delivery.

Good

Surgery

The centre manager was responsible for business functionality. The manager described a structure with minimal layers which allowed staff to be empowered and allowed them to receive support from the doctors.

The leaders had the skills, knowledge and experience they needed to ensure the service met the patient's needs. The doctor told us how they maintained their professional knowledge with attendance at national conferences as well as revalidation and demonstrated an open door policy for staff.

Staff demonstrated how they strived to be professional, open and inclusive to those who used this service, for example we spoke with two patients who travelled from outside the county as they felt this service provided them with " a high quality service" and " I really would not want to go anywhere else for this service".

The medicines management policy was due for review by December 2019 and managers told us this was currently being reviewed by an independent pharmacist to ensure medicines were managed in line with national guidance to keep patients safe.

Staff spoke positively about the manager and medical directors of the service.

Vision and strategy

The service had a vision for what it wanted to achieve but not a clear strategy to turn it into action. Staff understood the vision and knew how to apply and monitor progress

The service had a vision but not a clear strategy which the manager referred to as the statement of purpose. The manager and doctor told us the service aimed to make clients feel that their appearance and wishes matter to each and every one of the team and through continuity of care and getting to know staff, that they feel just how important as a client they are, both personally and professionally. Staff were aware of the vision and worked to meet the requirements of the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The service had an equality and equal opportunities policy which was included in the staff handbook.

The service had an open and honest culture that supported fairness. There was a no blame culture and an open door approach to the manager and doctors.

Staff told us how they enjoyed their work and worked well together. We observed good teamwork within the service across all disciplines. All staff were able to access the medical directors when they needed them and felt valued.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was an effective governance framework to support the delivery of quality patient care. The process include monitoring of patient outcomes and location risks. Monthly communication meetings were held with the staff and records shared with staff not present at the meeting, we saw minutes from meetings held from March 2019 to August 2019, for example which included updated guidance and the fire training date.

When staff commenced working for this service they received contracts which included their role and accountabilities. Staff met monthly with the doctor to discuss any concerns or opportunities in their roles. The service had checks in place to ensure that high standards of care were always maintained. This included updated policies and guidance, although not all were referenced, for example the whistleblowing policy they followed national guidance and were reviewed regularly.

All risk assessments reviewed had been completed and the risk register included appropriate risks, for example, needlestick injury There was no participation in national audits or benchmarking with other providers outside this service.

We saw a daily patient workplan which provided oversight of the work completed by the service.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had no plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a risk assessment policy. The policy outlined arrangements for all organisational risks through the completion of appropriate risk assessments.

A risk register was in place and detailed appropriate risks which included a brief description of actions required to minimise the risk, a risk score and who was responsible for the risk, for example, staff needlestick injury and Hepatitis B status. Hepatitis B is a disease of the liver caused by a virus which can be prevented by vaccination.

There was no business continuity plan, for example, in the event of a major incident or loss of resources.

The service completed internal monthly audits which included medication, equipment and records audits. Results were used to improve patient experience. Information Governance and confidentiality were included as part of the staff induction training programme, which ensured that staff were aware of the requirements of managing patient's information and that information was managed in line with the General Data Protection Regulations (GPDR).

The manager was the designated fire marshal for the clinic and had completed training for this role.

Managing information

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.

Staff had access to the organisation's computer systems and could access latest guidance and communication about changes for the service.

Computer terminals were locked during the inspection or manned to prevent unauthorised access to patient information.

Managers showed us that data relating to patient outcomes was routinely monitored. The results from patient surveys were reviewed and used to improve the service where indicated, for example the sclerotherapy information leaflet and consent form included side effects and post treatment care.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public to plan and manage services.

Patient's feedback was collected and used to shape and improve the service. Patient's feedback was gathered after treatment. Patients told us that they were fully involved in decisions about their care and were given time to ask questions and their concerns were listened to by staff.

Patient's considering treatment were provided with the right information to help them make the best decision about their choice of treatment or surgery. This included how the procedure was performed, cost and risks including complications.

All patient feedback was included and discussed at team meetings.

There was a website for patients to use which included on line access enquiry form for patients to submit and included the type of treatments the service offered.

We reviewed the 360 degree feedback from staff and patients for the doctor's appraisal. All staff were given a detailed induction handbook with benefits of working for the service which included rewards and pension entitlement.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a understanding of quality improvement methods and the skills to use them.

Good

Surgery

The manager provided evidence to support continuous learning and improvement, for example the improvements with the refurbishment of the minor surgery area to meet (Department of Health (DH) Health Building Note 00-10 Part A: Flooring (2013)).

Staff innovation was supported with attendance at conferences and regular staff development completed which focused on improvement and learning.

Staff were given time out to review and make improvements, for example, staff training in specialist areas within this service, for example, we heard that one staff was supported while completing their national vocational qualification.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all daily drug fridge temperatures are recorded and that the drug fridge is locked when unattended.
- The provider should ensure all guidance and policies have relevant references.
- The provider should ensure that a strategy is developed and known by staff.