The Chiswick Hair Clinic Ltd

The Chiswick Hair Clinic

Inspection report

Doherty House
2 Heathfield Terrace
London
W4 4JE
Tel: 07928762742
www.chiswickhairclinic.com/

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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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

The Chiswick Hair Clinic specialises in hair transplantation for male pattern baldness, alopecia and hair loss. The treatment consists of Follicular Unit extraction (FUE) and implantation (Hair transplant procedures) and is carried out by a doctor under local anaesthetic with the patient fully conscious and awake throughout the entire procedure.

The service is registered to provide the following regulated activities:

- Surgical Procedures

There has been a registered manager in post since the service registered with CQC.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 24 January 2022. During the inspection we visited reception areas, waiting areas, the treatment room and a consultation room. We spoke with two senior staff members, including the registered manager who was also the clinic manager and the only employed hair transplant surgeon for the service. We spoke with one member of administrative staff via telephone.

The key questions we asked during this inspection were, was it safe, effective, responsive and well-led. Due to the low patient activity, we were unable to assess nor rate the caring key question.

We have not previously inspected this service.

Post-inspection, we invited the provider to send us further information evidencing compliance and improvement following initial feedback from our inspection findings. It was clear the provider had taken inspectors feedback seriously and was completing a programme of change to rectify all issues highlighted. We reviewed evidence, post-inspection, which demonstrated the provider was implementing positive changes. We will continue to monitor these changes through continual engagement.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	We have not previously rated this service. We rated it as requires improvement because: • The provider did not have suitable arrangements for staff to follow, which protected patients from the risk of harm related to the taking of and use of photography. • The provider did not have effective systems in place for managing risk. • The provider did not have a service specific complaints policy and it was unclear what the process for raising a complaint was. • The provider was unable to demonstrate a systematic approach to the annual performance review process and regular staff reviews. • The policy for monitoring a deteriorating patient was not service specific and did not outline what staff should do when recognising someone becoming unwell. • There were no clear processes in place for investigating incidents. There was no demonstrable learning from any incidents we reviewed. • The provider did not have policies relevant to the service. • The provider did not ensure all staff members were up to date with their mandatory training. However: • The registered manager has shown a willingness to learn, improve and develop the service following feedback from this inspection.

Summary of findings

Contents

Summary of this inspection

Background to The Chiswick Hair Clinic

The inspection team consisted of two inspectors.

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.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement	Requires Improvement	Not inspected	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Not inspected	Good	Requires Improvement	Requires Improvement

Requires Improvement

Surgery

Safe	Requires Improvement
Effective	Requires Improvement
Responsive	Good
Well-led	Requires Improvement

Are Surgery safe?

Requires Improvement

Mandatory Training

The service could not demonstrate that all staff had completed mandatory safety training.

Most staff were employed directly by the service and there was an expectation that all staff working for the service would complete mandatory training to enable them to work there. However, the service was unable to demonstrate that all staff were compliant with mandatory training.

We reviewed four staff members training records and noticed between these staff; 10 mandatory training subjects were out of date. For example, we noted for one member of staff their sepsis awareness training had not been completed since 2018. Other subjects which were out of date included fire safety, hand hygiene, manual handling and privacy and dignity. It was unclear from speaking with the registered manager, the frequency of when these should be completed, although it was presumed by the registered manager to be annually, which would mean these subjects were not in date.

The registered manager was able to demonstrate compliance with their own required mandatory training subjects.

The registered manager was unable to demonstrate how they had chosen which training subjects were mandatory for staff to complete. The mandatory training policy in place was not service specific and did not detail which subjects were mandatory and for which staff groups this applied.

It was unclear how often the registered manager checked staff compliance with mandatory training or whether the system used to complete mandatory training flagged when staff were out of date with their training requirements.

Post inspection, inspectors were provided with evidence of an email sent to all staff members from the registered manager which indicated the training staff were required to undertake. The training was being delivered by a third-party company and the recommendations of which subjects staff should complete was outlined by this company.

Safeguarding

Staff understood how to protect patients from abuse, however, the safeguarding policy and procedure did not reflect details specific to the service.

Requires Improvement

Surgery

The service had an adult safeguarding policy; the designated safeguarding lead was the registered manager. The policy in use was not specific to the service, for example, it did not outline details of how staff should raise a safeguarding concern and did not detail who the safeguarding lead was.

Two members of staff we spoke with were clear about how to raise a safeguarding concern. One member of staff was able to name the person at the local authority safeguarding team, whom they would refer any concerns onto. However, the safeguarding policy did not contain any information regarding local authorities.

In the four staff records we reviewed we could see staff had completed safeguarding level 2 training and the registered manager had completed safeguarding level 3 training. It was also clear when refresher training was due for staff.

Post inspection, the registered manager provided inspectors with information relating to the contact details of key people related to safeguarding. This included the details of local authority contacts. The registered manager told us this would be implemented into a new, service-relevant, safeguarding policy.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Equipment and the premises were visibly clean.

Staff followed infection control principles related to COVID-19, including the use of personal protective equipment (PPE), During our visit, all staff and patient were wearing protective face coverings. There was hand sanitiser in the reception area and each room for staff and patients to use.

The registered manager told us they advised patients to perform a lateral flow test to identify any COVID-19 positive patients, however, this was advisory only.

The registered manager told us that patients and staff had their temperatures taken upon entering the clinic. We saw evidence of these checks being recorded.

Although equipment was not labelled to show when it was last cleaned, we did see evidence of a cleaning schedule and completed checklists of cleaned equipment. For general cleaning, the clinic outsourced to a third-party company. We saw evidence of a checklist which cleaning staff completed once cleaning had taken place. For specialist equipment, this was cleaned by staff employed within the service who had knowledge on how that equipment should be cleaned.

Some items of equipment were not for single use, and these were sent to an external company for cleaning and re-sterilisation. We saw evidence of the contract for the sterilisation agreement between the clinic and the company. Staff reported no problems with this agreement and felt they always had enough equipment to use in the clinic.

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 design of the environment followed national guidance, including the use of specialised ventilation in the treatment room.

Staff carried out daily safety checks of specialist equipment. We saw evidence of a maintenance log of equipment being completed.

Requires Improvement

Surgery

The service had suitable facilities to meet the needs of patients, including areas where they could sit comfortably and wait for their procedure.

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

Staff disposed of clinical waste safely. We saw evidence of contract agreements between the clinic and an external waste management service.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. However, there was a lack of evidence the service was using a consistent approach to assessing patient risk.

Risk assessments were carried out on patients to ensure their suitability for the procedure, evidence of venous thromboembolism (VTE) assessment was found on inspection.

The service used the National Early Warning Score (NEWS) during a patient procedure on the day of inspection. NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. However, the registered manager was unable to provide evidence NEWS had been used on four patient records we reviewed. No further information was provided post-inspection to evidence NEWS had been used on these patients.

Post inspection, the registered manager provided updated forms which the clinic will be using for all patients, which included the nature of the observations to be carried out which contribute to a NEWS score.

The policy for monitoring a deteriorating patient was not service specific and did not outline what staff should do when recognising someone becoming unwell. This posed a risk to patient safety because staff did not have written guidance to support them in recognising or responding to a deteriorating patient to keep them safe during and after a procedure. We did not see evidence staff had completed any deteriorating patient training or similar.

All procedures were carried out under local anaesthesia and dependent on the procedure being carried out, could last from one hour to four hours in duration. During hair transplantation, the patient would have the procedure carried out by a hair transplant surgeon who was supported by up to four hair transplant technicians. Treatment was carried out as an outpatient, and once the patient stated they felt well and showed no signs of clinical deterioration, were free to leave unaided.

The hair transplant technician was responsible for ensuring the patient was appropriately monitored during the procedure. For example, the hair transplant technician undertook clinical observations on the patient during the procedure and ensured the patient remained in a comfortable position.

A review of four patient records showed that clinical observations were recorded several times during the procedure. The registered manager told us that clinical observations should be taken at varying intervals throughout surgery. However, there was no policy or guidance in use which suggested how often clinical observations should be taken. All surgical notes were recorded on paper and scanned onto an electronic record platform.

Requires Improvement

Surgery

Post operatively, patients had access to a telephone number in the event of any post-surgical complications or advice. It was unclear who manned this telephone number as the registered manager was unable to specify. This service was available during business hours. Patients were instructed to contact an out-of-hours doctor or A&E outside of these hours if they had any concerns.

Staffing

The provider ensured clinical support staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm.

The service employed all members of staff and did not have any medical staff working on practising privileges arrangements. There were two support staff who were contracted to work for the service providing administrative duties, these two members of staff worked from home.

There was only one hair transplant surgeon working for the service, who was also the business owner. This surgeon worked on a full-time basis with limited weekend working. The surgeon did not hold an NHS practice and we saw evidence of an annual appraisal for this staff member.

We asked to see evidence of staff appraisals and regular one-to-one discussions completed between senior staff and other members of staff. No evidence was provided to us during or after the inspection. It was unclear from speaking with the registered manager, whether staff had undertaken a 1:1 and it wasn't recorded or whether a 1:1 had not been completed.

Staff had their training credentials checked prior to employment.

The service had enough staff to keep patients safe and did not use any bank or agency staff. The service did use one regular freelance hair transplant technician.

Records

Staff kept records of patients' care and treatment. However, records were not always clear or up to date. Records were stored securely but not always easily available to all staff providing care.

Patient notes were not always comprehensive, with different parts of a patient record being held across multiple IT software systems. For example, the procedure form, which was a paper copy and filled out during a patient procedure, should be scanned and added to the rest of the patient's electronic records. However, the registered manager told us this did not always happen. When asking for a complete record for one patient, the registered manager was unable to find all relevant information for that patient.

Patient notes were inconsistent in their style and detail. We reviewed four patient records and noted that all of them detailed differing degrees of patient information. Two of the records we reviewed detailed very little notes throughout, including a lack of medical history, allergies and medicines the patient was taking.

There was no patient record policy in place, however, records were stored securely.

Medicines

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

Requires Improvement

Surgery

Staff safely prescribed, administered, recorded and stored medicines. However, the service did not have a service specific medicines management policy,

The service did not have a medicines management policy specific to the service in place. There was no information available for staff on the safe storage, use and disposal of local anaesthesia – the main drug used in hair transplantation surgery. However, staff had a good understanding of how to carry out their responsibilities in relation to local anaesthesia.

The service did not use any controlled medicines.

Post inspection, the registered manager provided us with evidence of an information leaflet which was given to patients who are provided with medication. This leaflet contained information on how to access other services in the event of any queries or questions whilst the clinic was closed.

Incidents

Staff recognised and reported incidents and near misses. However, there was no evidence that incidents were investigated, and shared lessons learned with the whole team and the wider service.

Although the service did not have an incident reporting policy, staff knew what incidents to report and how to report them. The service had an incident logbook which had a description of the incident and any immediate actions taken; however, we did not see any follow on from this. There was no information available to show that incidents had been investigated and no evidence of any shared learning across staff had taken place. We saw no action had been taken to minimise or reduce the reoccurrence of any incident.

The service had not had any serious incidents or never events.

The service did not monitor themes or trends regarding reported incidents. We noted at least eight incidents logged in an incident logbook but there was no identification of recurring themes. We noted two incidents were similar in nature, relating to patient expectation not being met, however, the registered manager did not collect any trend analysis of incidents.

Post inspection, the provider sent us evidence of detailed case studies, including details of incidents, actions, outcomes and lessons learnt from those incidents. The registered manager told us they were working towards embedding lessons learnt from incidents amongst all staff and would keep CQC updated on the progress of this.

Post inspection, the provider also sent us a copy of a significant events policy and procedure, with forms to be completed in the event of a significant event taking place.

Are Surgery effective?

Requires Improvement

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, the services' policies were not specific to the service and did not detail relevant information.

Requires Improvement

Surgery

Policies had not been adapted or revised to ensure they fitted the scope of the service. Information contained in several policies showed they were more relevant to a hospital setting. However, staff we spoke with were able to inform us about the latest guidance used to inform best practice. For example, the operating surgeon told us they regularly reviewed information provided by the British Association of Hair Restoration Surgery (BAHRS).

The service had not instigated a process to evidence and record that staff had read and understood all policies.

We saw evidence of National Institute for Health and Care Excellence (NICE) guidance within the clinic and documents with the latest guidance regarding hair transplantation and cosmetic procedures.

Post inspection, the registered manager provided evidence of an oxygen usage policy. The registered manager told inspectors they had a commitment to ensuring all policies were relevant to the service and were currently undertaking a review of the clinics policies.

Post inspection, the registered manager provided further updated policies related to electrical safety testing, a chaperone policy, blood and bodily fluids policy and a legionella testing policy with associated log sheets. These policies were service specific and contained relevant information for staff to follow.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

As procedures could last over prolonged periods, patients were given a break during treatment for food and drink.

Pain relief

We did not see evidence that patients had their pain assessed and recorded. We could not be assured patients had access to pain relief in a timely way.

It was not clear from four patient records we reviewed that staff had assessed their pain during and after the procedure. The service did not use a recognised tool, such as a numerical rating scale (NRS). (0 being no pain and 10 being extreme pain). We were not assured staff gave pain relief in line with individual needs and best practice.

We reviewed four patient records during inspection which evidenced that staff had recorded the administration of local anaesthetic detailing type, batch number, amount, expiry date and site of administration.

Staff told us that mild pain relief was not routinely prescribed for the patients to take home. However, the registered manager informed us that patients would be given advice by the operating surgeon on over the counter pain medications they could take and informed of the need to access their GP if stronger pain relief was required.

We were not reasonably assured from our discussion with the registered manager that they fully understood the requirements of registration to participate and undertake audit practice to monitor and improve patient outcomes. For example, we did not see any evidence of audits related to pain assessment and management practices.

Patient outcomes

The provider did not monitor the effectiveness of care and treatment and audit practice was not fully developed or carried out in practice. The provider did not actively monitor post-surgical infection rates.

Requires Improvement

Surgery

We did not see any evidence the provider held meetings with staff to discuss audits or review performance, including outcomes for patients. The registered manager was unable to produce any evidence of data relating to the service. There was no collection of information from patients post-procedure, apart from a welfare telephone call in the week post-surgery.

We were able to see that patients had always been given a post-procedure telephone call from the clinic manager. However, it was unclear at which stage this phone call took place and the nature of the call. Of the four patient records we reviewed there was an inconsistent approach to documenting the telephone discussion and in one patient record we could only find one call which had taken place post-procedure, despite the registered manager telling us the patient received more than one call.

Post inspection, the registered manager provided inspectors with a schedule of audits which are to be undertaken during the year and which month each audit was to be undertaken in. The registered manager agreed to provide CQC with audit information once audits had started to be completed.

Also post inspection, the provider sent inspectors a formal agenda for future meetings. Included in this evidence was an outline of the expected daily and weekly communications which will be sent to staff. Documentation provided showed itemised subjects for routine inclusion in staff communications.

Competent staff

The service made sure staff were competent for their roles. However, we did not see evidence of managers appraising staff's work performance.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

We did not see evidence of managers supporting staff to develop. There was no documented evidence of staff appraisal or any objectives, aims or goals for the year. We reviewed four staff records and found no evidence of appraisals.

Multidisciplinary working

All staff worked together as a team to benefit patients. They supported each other to provide good care.

We saw evidence that staff worked well together in the best interest of patients. Members of staff we spoke with told us that team working was well established within the service and they had no issues working with their colleagues.

Seven-day services

The service was open Monday to Friday at varying times depending on patient activity.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Consent was obtained in line with the Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery (April 2016) which states that, consent should be gained by the doctor who will be delivering treatment, 14 days prior to treatment, to ensure the patient has a cooling-off period. Of the four patient records we reviewed, all records showed that a minimum of 14 days had been achieved between initial consultation and procedure.

Requires Improvement

Surgery

The patient had a face to face initial consultation with the operating surgeon. As there was only one surgeon employed by the service, the consulting surgeon was always the operating surgeon.

Are Surgery responsive?

Good

Service delivery to meet the needs of local people

Service delivery to meet the needs of people. The service planned and provided care in a way that met the needs of local people and the communities served.

Facilities and premises were appropriate for the services being delivered.

Patients were provided with post-discharge care information, which included clinic contact details for post-operative advice and specific instructions about hair care.

There were two parking spaces available at the clinic. The clinic was easily accessible by public transport.

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.

The clinic provided treatment for male, female and trans-gender patients.

The appointment system appeared easy to use and supported people to access appointments. Patients could arrange an appointment by telephone or make an enquiry using the clinic's website.

There was no wheelchair friendly access available at the clinic and no hearing loop available within the clinic.

The service was able to access written information in other languages but had not signed up for a telephone interpreter service. The majority of patients were English speaking and the registered manager told us an interpreter service would be used if needed.

Access and flow

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

All procedures were booked in advance. The clinic did not offer same day consultations but attempted to book in patients within 1-2 weeks of their requested date.

During the initial consultation the patient would be given pre-operative information and their expectations regarding the results of treatment were discussed. If the patient wished to continue

from here, the patient was booked in with the hair transplant surgeon for the procedure.

Requires Improvement

Surgery

Learning from complaints and concerns

The complaints procedure was displayed and explained to patients as to how they could give feedback and raise concerns about care received. However, the service had no complaints policy specific to the service.

The service had a complaints policy, but the content did not clearly outline the process patients should follow to raise a complaint. It did not detail the process staff should follow when dealing with a complaint, nor did it contain information relating to timeliness of complaint responses or information relating to Duty of Candour (DoC). However, attached to the reception desk was a complaints procedure which described how patients could complain via the Independent Sector Complaints Adjudication Service (ISCAS), of which the clinic was a member of.

The registered manager told us the service had not received any complaints since opening in 2017, therefore, no complaints investigation had taken place.

Post inspection, the registered manager provided inspectors with an updated complaints policy and procedure with information on how complaints should be handled and the timeframes for resolution.

Are Surgery well-led?

Requires Improvement

Leadership

Leaders did not have the necessary skills and abilities to run the service. They did not always understand and manage priorities and issues the service faced.

The registered manager was responsible for ensuring compliance by the provider with the fundamental standards of care. The registered manager was responsible for recruiting staff.

During the inspection the registered manager did not demonstrate an understanding of the obligations placed on them by their role as registered manager, and, how compliance with the fundamental standards of care helped to ensure maintenance of quality at the location and continuous improvement.

The registered manager was also the clinic manager. They had daily oversight of the running of the service.

Vision and Strategy

The service did have a vision for what it wanted to achieve but no formally written strategy of how it would turn this into action.

The registered manager told us they had an idea for expanding the service and using extra space to widen patient capacity. However, these were at the idea stage and there was no formal documenting of these future ideas.

Culture

Staff we spoke with felt respected, supported and valued. Staff told us they focused on the needs of patients receiving care.

Requires Improvement

Surgery

Most staff working for the service were unable to speak with inspectors during the inspection or thereafter due to patient activity and the inspection being unannounced. The staff

we did speak with felt there was a culture of teamwork and that every staff member strived hard to achieve excellence in patient care.

Governance

Leaders did not operate effective governance processes. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service.

There was no evidence of effective structures, processes and systems of accountability to support the delivery of service improvement and to ensure good quality sustainable care and treatment.

There were no governance structures for the service. We were told senior leaders held monthly meetings, but we did not see evidence that these meetings covered governance related topics such as incident analysis, complaints or health and safety matters.

We did not see evidence that all staff had opportunity to meet, discuss and learn from the performance of the service. We did see evidence of team meetings throughout the previous year, however, due to the lack of a clear agenda and minute taking it was unclear what discussion or actions, if any, arose from these meetings.

Post inspection, the provider told us they had now introduced a structured approach to staff engagement and meetings. The provider stated they would be willing to share minutes from staff meetings once the changes had been implemented and embedded.

Management of risk, issues and performance

It was unclear if any system was used to identify risks and there was no clear plan to eliminate or reduce them. The recognition and management of risks was not clear or routinely happening in practice.

We saw limited evidence that the service used systems to manage performance effectively. Leaders of the service did not demonstrate they had the knowledge or experience to fully embed systems to manage performance.

The service did not detail risks relating to the service. The registered manager had a lack of understanding on what constituted a risk, any mitigations or actions. The service did not have a risk register or any other similar document in place.

Risk assessments were not clear or routinely considered as part of everyday practice. It was unclear who carried out risk assessments and if staff understood the purpose of them.

Post-inspection, the provider sent inspectors copies of newly implemented risk assessments, including, environmental risks such as slips, trips and falls, staff immunisations and fire safety. The registered manager told us they had a programme underway to look at service-relevant risk assessments and would keep inspectors informed of other risk assessments which may be introduced in future.

Information Management

The information systems were integrated and secure. However, the provider could not demonstrate photographs were being taken in accordance with General Data Protection Regulation GDPR rules.

Requires Improvement

Surgery

Photographs of patients' treatment were taken, with consent, and uploaded to the patient record. It was unclear how the storage or deletion of the original photograph was managed. There was no image retention policy or similar which outlined how long images would stay on the clinic's system. The registered manager was unable to tell us how long images would be held for before being deleted, although they stated it would not be within the first 12 months of a patients' procedure. We were not reasonably assured the service was taking and securely storing photographs in line with General Data Protection Regulation (GDPR) requirements.

Post inspection, the registered manager provided evidence of patients consenting and agreeing to have photographs taken. We reviewed a photography and imaging policy which highlighted how staff must ensure compliance with GDPR. Inspectors were also provided with an Information Commissioner's Office (ICO) certificate, valid until May 2022. ICO certification demonstrates a commitment to compliance with GDPR regulations.

The service had invested in antivirus and firewall protection software. All computers we saw in use were password protected and locked when not in use.

Engagement

Leaders actively and openly engaged with staff. We did not see evidence of any patient engagement.

During the inspection, we saw evidence that staff had opportunities to meet and discuss the service. However, it was unclear from the minutes of these meetings what the discussions were centred around. We did not see evidence of a clear agenda which staff used to structure their meetings.

There was no evidence of staff involvement in the planning of the service. We did not see evidence of routine collection of patient feedback.

We saw there was a website which gave information about the service

Learning, continuous improvement and innovation

There was no evidence of innovation at the service.

During the inspection we did not see or hear about any examples of continuous learning, improvement or innovation. The service did not participate in any research projects or recognised accreditation schemes.

Post inspection, the provider sent inspectors evidence of a patient feedback form the service had designed and implemented following our inspection. The registered manager told us they would be using the information gained from this feedback to look at ways of improving the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Action the service MUST take is necessary to comply with its legal obligations. Action a trust 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 MUST take to improve**: • The provider must ensure they have suitable arrangements for staff to follow, which protect patients from the risk of harm related to the taking of and use of photography. • The provider must ensure there are effective systems in place for managing risks. • The provider must ensure complaints are handled in line with their own policy and demonstrate concerns are taken seriously and are investigated sufficiently. Outcomes of the investigation of complaints must be shared with all staff. • The provider must demonstrate a systematic approach to the annual performance review process and regular staff reviews. • The provider must ensure the policy for monitoring a deteriorating patient is service specific and outlines what staff should do when recognising someone is becoming unwell. • The provider must ensure there are clear processes in place for recording, reporting and investigating incidents. Learning from such investigations must be shared with staff. • The provider must ensure polices are relevant to the service and contain updated information. • The provider must ensure mandatory safety training is completed by all staff, that it is checked and reviewed regularly.

This section is primarily information for the provider

Requirement notices

Action the service SHOULD take to improve:

- The provider should ensure patient records are integrated into a single clinic record which is easily accessible to all staff.
- The provider should ensure the National Early Warning Score (NEWS) is accurately recorded and kept in the patients record.
- The provider should ensure pain scores are taken regularly and recorded in the patients record.