Westminster Clinic Limited

Westminster Clinic Limited - at 31 Harley St.

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We have not rated this service before. We rated it as inadequate because:

- Not all staff understood how to protect patients from potential abuse. The service did not consistently control infection risk, including the risk of COVID-19 transmission. The design, maintenance and use of facilities, premises and equipment was not consistent. Staff could not evidence they assessed potential risks to patients, and they did not keep detailed records of patients' care and treatment. The service did not manage patient safety incidents adequately, as we were not assured staff would recognise and report incidents and near misses. There was no evidence of any learned lessons from incidents.
- The service did not provide care and treatment based on national guidance or evidence-based practice. There was no record of staff assessing or monitoring patients regularly to see if they were in pain. Staff did not fully monitor the effectiveness of care and treatment or use the findings to make improvements and achieve good outcomes for patients.
- There was no process for people to escalate their complaints or concerns beyond a local level.
- The registered manager failed to demonstrate an understanding of how compliance with the fundamental standards of care helped to ensure maintenance of quality at the location. The service did not have a formal vision or strategy. The registered manager did not operate an effective governance process throughout the service and did not use systems to manage performance effectively. The clinic lacked a robust approach to quality improvement and made only limited improvements in response to feedback.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills. They managed medicines well.
- Staff provided gave patients enough to eat and drink. Staff worked well together for the benefit of patients and supported them to make decisions about their care. Services were available five days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. They provided support to patients.
- The service planned care to meet the needs of patients and took account of some patients' individual needs. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

This service is being placed into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Westminster Clinic Limited - at 31 Harley St.

Westminster Clinic Limited - at 31 Harley St. is operated by Westminster Clinic Limited. The service opened in February 2019. The service provides day case surgical hair transplant procedures to private patients over the age of 18. There are two methods of hair transplantation: follicular unit transplant and follicular unit extraction. The service provided follicular unit extraction. In follicular unit extraction, individual follicles are extracted and then implanted into small excisions in the patient's scalp. All procedures were undertaken using local anaesthesia.

There has been a registered manager in post since the clinic opened in 2019.

The clinic is registered to provide the following regulated activities:

- Surgical Procedures

Activity (May 2020 to 18 May 2021):

- The clinic carried out 84 day case hair transplant procedures.
- There were 129 consultation appointments.

There was one doctor working at the clinic, who was training one other doctor at the time of inspection. The service employed one lead hair technician, one clinic manager and one member of administrative staff. Other hair technicians were not employed permanently by the service but were called upon as required when there was patient treatment.

We have not previously inspected this service.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 18 May 2021. We gave staff 48 hours' notice that we were coming to inspect to ensure the availability of the registered manager and clinics.

During the inspection, we visited the whole clinic, including the reception, waiting area, theatre and consultation room. We spoke with four staff including hair technicians and the registered manager. We spoke with one patient and reviewed 10 sets of patient records.

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

Areas for improvement

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

Action the service MUST take to improve:

Summary of this inspection

We told the service that it must take action to bring services into line with legal requirements.

- The service must ensure patient risk assessments are robust and adequately documented, including the initial consultation stage of treatment, psychological assessment and medical history. (Regulation 12(1))
- The service must ensure there is a formally documented admission policy or exclusion criteria for patients seen at the clinic so it is clear who can and cannot be accepted for treatment at the clinic. (Regulation 12(1))
- The service must ensure there is a formally documented procedure to follow in the case of a patient deteriorating or becoming unwell, including ensuring physical observations are documented at appropriate intervals during treatment. (Regulation 12(1))
- The service must ensure they review guidance in relation surgical safety checklists and implement this as required within their service. (Regulation 12(1))
- The service must ensure adequate measures are taken to mitigate against the risk of COVID-19 transmission. (Regulation 12(1))
- The service must ensure full and complete records of both external and staff cleaning are maintained and challenged where incomplete. (Regulation 12(1))
- The service must ensure all staff understand their responsibility to report incidents that affect the health, safety and welfare of people using services, and improvements are made as a result of any such incidents. (Regulation 12(1))
- The service must ensure they are following the Control of Substances Hazardous to Health (COSHH) Regulations 2002. (Regulation 12(1))
- The service must ensure staff are aware of the actions to take in the event of a fire in the clinic. (Regulation 12(1))
- The service must ensure all policies and protocols are reviewed in order to fit the scope of the business and reference current national guidance, including their complaints policy. (Regulation 17(1))
- The service must ensure local audits are meaningful and drive improvement where required. (Regulation 17(1))
- The service must ensure patient records are accurate, complete and contemporaneous. (Regulation 17(1))

Action the service SHOULD take to improve:

- The service should ensure all staff know how to escalate safeguarding concerns and are able to demonstrate awareness of potential safeguarding issues.
- The service should ensure all electrical items have been safety tested.
- The service should ensure the clinic environment is free from clutter and out-of-date items.
- The service should ensure sharps are managed safely.
- The service should ensure staff are fully aware what the term ‘duty of candour’ (DoC) means.
- The service should consider introducing a method of pain scoring to their documentation used with patients.
- The service should consider how to formally record the training and competency of doctors being trained at the service.
- The service should ensure the registered manager develops an understanding of the fundamental standards of care and their obligations as registered manager.
- The service should consider introducing a formal and strategy.
- The service should ensure risk assessments are comprehensive and regularly reviewed and updated.
- The service should ensure they are following their information governance policy.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

Inadequate

Surgery

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

Are Surgery safe?

Inadequate

We have not rated safe before. We rated it as inadequate.

Mandatory training

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

Mandatory training required to be undertaken by all those who worked for the service included: fire safety, equality and diversity, infection control, safeguarding adults and children, manual handling, basic life support and information governance. There was a clear log kept with each staff record of when their training would expire.

Safeguarding

Most staff understood how to protect patients from abuse and had training on how to recognise and report abuse.

All staff completed safeguarding adults and children training (level one) as part of their mandatory training, apart from the member of administrative staff. The lead doctor had completed level two adult safeguarding training, and the clinic manager (who was the nominated safeguarding lead) had completed level three safeguarding adult training. However, not all staff we spoke with knew how to escalate safeguarding concerns or demonstrated awareness of potential safeguarding issues. The safeguarding policy had been updated but was still not tailored to the nature of the service provided. Although the nature of the service meant they were unlikely to encounter a high volume of vulnerable adults, we were not fully assured the service would appropriately report potential abuse and neglect.

Cleanliness, infection control and hygiene

The service did not consistently control infection risk, including the risk of COVID-19 transmission. 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.

Inadequate

Surgery

Although we observed social distancing within the clinic and use of appropriate personal protective equipment (PPE) and hand sanitiser, there was no mechanism for COVID-19 testing of day case patients or asymptomatic staff. Patients were asked to fill out a screening questionnaire and had their temperatures taken prior to admittance to the clinic. The clinic's policy indicated increased cleaning of high touch areas, although there was no formal record kept of this. Although the service told us there had been no instances of COVID-19 transmission, it was unclear how they mitigated against the risk of asymptomatic transmission or knew whether this had occurred. Although at the time of inspection levels of COVID-19 were low in the UK, this had not been the case historically.

There had been no surgical site infections in the 12 months prior to our inspection.

There were inconsistent records of external cleaning, with missed checks on several days over the last two months. There were no records kept of any items staff cleaned, including clippers used to cut patients hair. The service did not undertake hand hygiene audits. This meant there was limited evidence of sufficient controls to prevent the spread of infection. Following inspection, the service told us they had spoken to the external cleaners about issues with cleaning records and had introduced a checklist for staff cleaning, although this was not shared.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment was not consistent. Staff managed clinical waste well.

Most equipment had evidence it had been recently tested or maintained, apart from two blood pressure cuffs. There was a high level of clutter and unused items within the clinic, which the lead doctor told us were no longer in use. Underneath the hand basin, we found cleaning products stored next to saline and baby oil given to patients. These were not covered by the Control of Substances Hazardous to Health (COSHH) risk assessments viewed on the day of inspection, meaning there were insufficient control measures in place prevent or reduce exposure to these potentially hazardous substances.

There was a service level agreement in place with a provider to collect clinical waste. The clinical waste was disposed of in suitable bins which were stored outside the property. However, the two sharps bins in the theatre had not been labelled and the temporary closures were not in use. Environmental audits viewed on the day of inspection indicated these were labelled and temporary closures were in use, so we were not assured these audits were carried out meaningfully.

Due to the nature of the service they did not require a resuscitation trolley. However, they did have a first aid box, although this was overfull and thus not appropriate for use in the case of an incident where the box may be required. Following inspection, we were informed contents of the first aid box were being reviewed. There was a defibrillator in the building. There was an oxygen cylinder in the theatre for use in emergency, but this was unsecured and stored next to combustible items, presenting a potential fire hazard. Following inspection, the provider told us they had reviewed the storage of the oxygen cylinder with the help of the external contractor.

Fire extinguishers were accessible, stored appropriately, and were all up to date with their services. However, staff had not completed any fire drills, so may not be aware of the actions to take in the event of a fire. On the day of inspection, the provider told us fire drills were the responsibility of the owner of the building. Following the inspection, the lead doctor and head technician had arranged to attend fire drills regularly and cascaded information to other staff about what to do in the event of a fire.

Assessing and responding to patient risk

Inadequate

Surgery

Staff could not evidence they completed risk assessments for each patient to minimise risks. Staff identified and quickly acted upon patients at risk of deterioration, but there was no formal process or documentation in place.

Pre-operative assessments were undertaken by the doctor undertaking the procedure. However, the process surrounding patient assessment was not robust or adequately documented. The initial consultation stage was documented on a blank sheet of paper, with no consistent record of the discussion with the patient and any risks, benefits, agreed costs or their suitability for the intended procedure. Patients were not formally psychologically assessed prior to treatment and there was no clear process in place for identifying psychologically vulnerable patients. The medical history section of patient records was incomplete or blank in five of the 10 records we looked at. In addition, there was no formal admission policy or exclusion criteria in relation to patients who could or could not be seen at the clinic. The registered manager told us that patients seen at the clinic were young and fit, with no past medical history of note, and so this was why the medical history sections were left blank in the records. They told us that assessment for clinical suitability took place at the initial consultation and further action would be taken where concerns were raised, such as obtaining information from the patient's GP. However, the lack of formal documentation or policies surrounding this meant we could not be assured risks to patients were being appropriately assessed and that appropriate control measures could thus be taken to minimise any potential risks.

Staff told us what action they would take if a patient was at risk of deterioration. All clinical staff were basic life support (BLS) trained. In the case of emergency, the patient would be transferred to the most appropriate neighbouring NHS hospital, using the standard 999 system. Earlier in the year, there had been an incident where a patient had fainted which was managed appropriately by staff. However, there was no formal written policy detailing what action staff should take if a patient became unwell. There was no record of the physical observations of patients, although the lead doctor told us these were taken in the course of each appointment. The service did not use the World Health Organisation (WHO) surgical safety checklist for patients to prevent or avoid serious patient harm. The lead doctor told us that they did not believe the WHO checklist was appropriate for the minor surgical procedures undertaken at the clinic, but they had added some elements such as the pain scale to the patient record. However, this was not the case on the day of our inspection. We were not assured there were sufficient controls to ensure staff would appropriately identify patients at risk of deterioration.

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. There was a formal induction process for new staff.

There was one lead doctor who completed all of the surgical hair transplants. The lead hair technician was contracted for two days per week. The service employed four other hair technicians on zero hours contracts on a regular basis.

All staff we spoke with felt the staffing levels were sufficient to cover the work required. Procedures would be cancelled if needed, where the lead doctor was unwell, for instance.

Records

Staff did not keep detailed records of patients' care and treatment. Records were not clear or up to date, although they were easily available to all staff providing care on the day of each procedure.

Inadequate

Surgery

The 10 records we looked at on the day of inspection were incomplete and inconsistent, with missing checks and incomplete sections throughout, as described in other sections of this report. The provider supplied a document indicating notes were audited but there was no detail of how this was carried out and no collated results or agreed actions documented as a result of this audit. It was unclear how potential improvements to documentation would be identified and actioned.

Medicines

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

Allergies and medication given to patients were clearly documented in records. There was a service level agreement (SLA) in place for the supply of medicines. All medicines we checked were within date and stored appropriately. The service did not use any controlled drugs or prescribe antibiotics.

Incidents

The service did not manage patient safety incidents adequately, as we were not assured staff would recognise and report incidents and near misses. Were things to go wrong, staff told us they would apologise and give patients honest information and suitable support but not all staff were aware what this entailed. The clinic manager had a process to ensure actions from patient safety alerts were implemented and monitored.

Staff did not have a clear understanding of what an incident was, although they knew how to report this in theory. There had been one incident reported in the last 12 months, of which the whole team was aware. We saw that the team had discussed this incident and each member of staff was able to talk about what had occurred. However, there was no record of actions taken to reduce the risk of reoccurrence of a similar type of incident.

Not all staff were fully aware what the term 'duty of candour' (DoC) meant. The DoC 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.

Are Surgery effective?

Requires Improvement

We have not rated effective before. We rated it as requires improvement.

Evidence-based care and treatment

The service did not provide care and treatment based on national guidance or evidence-based practice.

We reviewed the service's existing policies and protocols and found they did not fit the scope of the business or reference current national guidance, with outdated terminology used and references to practices not relevant to the service. Only some of the policies contained a date of drafting, review date or version control and many contained typographical errors. Following inspection, the service indicated these policies would be reviewed in July 2021 (although this was later brought forward). We were not assured the clinic was following current best practice guidance.

There were no written policies or protocols regarding what to do in the event of a deteriorating patient or emergency situation, or who would be accepted for treatment at the service. The registered manager could articulate these but nothing formal had been drafted to record them. This meant there was a risk in inconsistency in practice between different staff members and that procedures at the clinic would not reflect current national best practice.

Nutrition and hydration

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

The clinic provided bottled water to all patients. As procedures could last over prolonged periods, patients were given a break during treatment for food and drink. Staff asked about patients' dietary requirements before buying them sandwiches from a local café.

Pain relief

Staff gave pain relief in a timely way, but there was no record of staff assessing or monitoring patients regularly to see if they were in pain.

Due to scheduled activity on the day of inspection we did not observe patient procedures. There was evidence in patient records that staff recorded the administration of local anaesthetic detailing type, batch number, amount, expiry date and site of administration.

The service did not use pain scoring or include this as part of the documentation. Following inspection, the service told us they had added pain scoring to their patient record template, but this had not been introduced at the time of inspection. In feedback reviewed from patients, one reported a high level of discomfort during their procedure. Patients were advised to purchase paracetamol over the counter for post-operative pain relief.

Advice was discussed pre and post operatively about what to do if discomfort became significant. We did not see the provider's post-operative care advice leaflet although this was requested.

Patient outcomes

Staff did not fully monitor the effectiveness of care and treatment or use the findings to make improvements and achieve good outcomes for patients.

The service did not have a formal clinical audit schedule in order to monitor patient outcomes and experience. Where audits were in place for health and safety or documentation, these were not wholly accurate and did not contain details of any actions that would be undertaken to improve compliance. This meant opportunities to improve the service could be missed.

Contact details of the lead doctor were given to patients along with instructions to contact the service at any time should any complications or questions arise. We saw evidence in some records that a follow-up call had been undertaken following hair transplant procedures, but this was not documented in four of the 10 records we looked at. Patients were seen 12 months after their procedure for a follow-up appointment to review their results, as the lead doctor indicated this was when the full effect of treatment became apparent. In response to patient feedback, the lead consultant told us they were considering introducing a follow-up appointment six months post-procedure.

Inadequate

Surgery

Competent staff

The service made sure most staff were competent for their roles.

We saw evidence of mandatory training completion, appraisal meetings and current disclosure and barring service (DBS) checks in staff files on the day of inspection. Minutes from a training day for all staff held in April 2021 detailed some areas of training and development that had taken place. The lead hair technician told us she attended international hair transplant conferences in the past with the lead doctor. Other staff did not complete any continuing professional development (CPD) or training relating specifically to their work at the service as they were employed on zero hours contracts.

The lead doctor was licensed with the General Medical Council (GMC), had a current appraisal and had undertaken training relevant to his role. He was currently supporting another doctor registered with the GMC to learn how to undertake hair transplant surgery. Although there is currently no recognised training or accredited qualification for hair transplant surgery in the UK, there was no documentary evidence of a clear formalised process for this training taking place such as competency documents or a policy. We were not clear how the lead doctor managed this process and ensured a clear record was kept of the training delivered to the second doctor.

Multidisciplinary working

The healthcare professionals provided regulated activity worked together as a team to benefit patients. They supported each other to provide good care.

Staff told us there were positive working relationships between all individuals as the service as it was a small team.

In the records we saw evidence that patients were asked whether they consented for their information be shared with their GPs.

Seven-day services

The service was available five days a week to support timely patient care.

Appointments could be booked between 9am and 5pm, Monday to Friday.

Health promotion

Staff gave patients advice in relation to their procedure.

There was patient information on procedures available on the service's website and in information emailed to patients.

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. There was a policy on how to support patients who lacked capacity to make their own decisions.

Inadequate

Surgery

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 to consider their decision to go ahead with surgery. Although the initial consultation documents in patient records were brief and handwritten, they were dated and so we were able to ascertain cooling-off periods were routinely given prior to a patient consenting to a hair transplant procedure. Consent forms were complete and signed in all 10 patient records viewed on the day of inspection.

There was a written policy relating to the Mental Capacity Act (2005), although staff did not receive specific training in relation to this. Staff reported they had never had an incident of a patient lacking capacity to consent and this was unlikely due to the nature of the service.

Are Surgery caring?

Good

We have not rated caring before. 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.

All conversations during and after an appointment took place in the private clinic room. Patients were greeted at the reception and taken through to the clinic room by staff. Feedback collated by the service indicated patients were happy with the care, treatment and service received. Patient comments indicated the staff were 'friendly and welcoming' and their experience was 'excellent'. We saw some examples of cards and emails from patients thanking staff for their good experience at the service.

Emotional support

Staff were able to describe how they would provide reassurance and support for nervous and anxious patients.

The provider told us staff spent time with patients both pre and post procedure carefully explaining the after care, recovery process and options to reduce any anxieties patients may have. Patient feedback indicated they felt able to call the service following their procedure for reassurance and advice.

Understanding and involvement of patients and those close to them

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

Patients were given clear information and preparation instructions via email before their appointment. Following their treatment, patients were given a post-operative instruction sheet, although we did not see a copy of this. In response to patient feedback which requested post-operative instructions be simplified, the service told us they were in the process of revising these to ensure they were as clear as possible.

Inadequate

Surgery

All costs were clearly stated on the provider's website and staff told us this was confirmed with the client prior to a scan being booked, although this was not clearly documented in all patient records.

Are Surgery responsive?

Requires Improvement

We have not rated responsive before. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of patients.

The clinic's location was close to public transport links. There was one clinical treatment room, a patient toilet, a consultation area and a waiting area downstairs. This was sufficient as only one procedure was conducted at a time.

Meeting people's individual needs

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

The clinic did not have wheelchair access due to its layout. The service was able to offer alternative solutions for treatment with other providers to patients if required.

Patients were given a choice of food which considered their individual and cultural preferences.

The service did not have access to formal translation services and would ask any patients to book their own translator if required. During the inspection, we were told there was no written information available in other languages or formats and staff seemed unsure as to how this would be provided.

Access and flow

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

Patients could arrange an appointment by telephone or on the website which appeared easy to use. All procedures were booked in advance at a time to suit the patient. Once the procedure was confirmed with the doctor, hair transplant assistants were contacted to support the procedure.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received initially, but there was no process for people to escalate their concerns beyond a local level.

Inadequate

Surgery

The service's complaints policy contained no details of how to escalate complaints beyond frontline resolution (stage one), so there were no arrangements in place for the independent review of complaints. The policy referenced the Independent Sector Complaints Adjudication Service (ISCAS) but the service was not subscribed to ISCAS at the time of our inspection. At the time of our inspection the provider had received no formal complaints.

Are Surgery well-led?

Inadequate

We have not rated well-led before. We rated it as inadequate.

Leadership

The registered manager had some of the skills and abilities to run the service. They did not fully understand and manage the priorities and issues the service faced. The registered manager was visible and approachable in the service for patients and staff.

The registered manager was also the CQC nominated individual and lead doctor. They delegated many tasks to the clinic manager, who did not work there full-time. During the inspection the registered manager did not appear to demonstrate an understanding of the obligations placed on them by their role as registered manager, and in particular, how compliance with the fundamental standards of care helped to ensure maintenance of quality at the location and continuous improvement.

For example, there was no meaningful local audit process in place and policies did not fit the scope of the business or reference current national guidance. Engagement with the provider prior to inspection had identified several areas for improvement, including the lack of arrangements in place for the independent review of complaints, the introduction of pain scoring and the adaptation of the WHO checklist, but no action had been taken as a result. Some actions had been taken in response to feedback given on the day of our inspection, but we were told actions such as decluttering the clinic would be not be taken until June 2021, and policies would be revised in July 2021. The revision of policies was later moved forward.

Staff told us they felt well supported by the registered manager, who they worked with on a regular basis.

Vision and strategy

The service did not have a formal vision for what it wanted to achieve, or a formal strategy to turn it into action.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

The policy on raising concerns contained outdated terminology.

Inadequate

Surgery

During the inspection, we were not assured the culture encouraged openness and honesty in response to incidents. There was a lack of understanding of the importance of recording incidents to learn and prevent recurrence. Staff were not fully aware of what the term 'duty of candour' meant.

Governance

The registered manager did not operate an effective governance process throughout the service. Staff at all levels were clear about their roles and accountabilities but we were not assured they had regular opportunities to meet, discuss and learn from the performance of the service.

The service had recently started to take minutes of their staff meetings, but these did not have a standing agenda or much detail. The service relied on informal sharing of information.

There was no effective system to review and update policies that were not fit for purpose. There were no written policies or protocols regarding what to do in the event of a deteriorating patient or emergency situation, or who would be accepted for treatment at the service. The registered manager could articulate these but nothing formal had been drafted to record them.

The lead doctor was registered with the General Medical Council and had indemnity insurance.

Managing risks, issues and performance

The registered manager did not use systems to manage performance effectively. They identified some risks and issues and identified some actions to reduce their impact.

There was no meaningful local audit process in place to monitor patient outcomes and experience. Where audits were in place for health and safety or documentation, these were not wholly accurate to circumstances we found at the clinic and did not contain details of any actions that would be undertaken to improve compliance.

Risk assessments were limited and did not identify most of the risks we found on our day of inspection. They were reviewed annually. The registered manager was not able to articulate what the main risks to the service were as the risk assessments had been drafted by the clinic manager.

No fire drills had been undertaken by the clinic staff on the day of inspection. Following our feedback, the lead doctor and head technician attended drills and cascaded information about what to do in the event of a fire to other staff.

Managing information

The service did not consistently collect reliable data and analyse it. Some information systems were integrated and secure. At the time of inspection, there was no process for data or notifications to be submitted to external organisations as required.

Inadequate

Surgery

There was an information governance policy that staff followed, but this did not contain full details of how paper notes were transported. Notes from the day of treatment were recorded on paper. At the end of each day, these notes were transported to the administrative office at a different location by the lead consultant to be stored securely. They used a lockable bag to store the files whilst being transported to prevent access to personal and sensitive information. This was not detailed in the provider's policy. Following our inspection, this policy was updated to include these details.

Initial referrals and photographs of patients' treatment areas were stored electronically. Staff told us these were stored securely. At the time of inspection, the service did not have access to the secure portal. It was unclear how the registered manger would send any notifications or data to the CQC. Following inspection, the clinic manager successfully requested access to the secure portal.

Engagement

The service engaged with patients and staff but there were limited opportunities for them to plan and manage services.

The service had recently started to take minutes of the staff meetings, but these did not discuss service developments or learning and improvement. There was no staff survey due to the small size of the service. Staff told us they would be comfortable suggesting improvements to the service directly to the registered manager.

The service had an easily accessible website where patients were able to leave feedback and contact the service. This showed patients were able to engage with the service online and verbally.

Learning, continuous improvement and innovation

The clinic lacked a robust approach to quality improvement.

At the time of inspection, the service lacked reasonable challenge from internal or external sources regarding quality improvement, governance, safety and effectiveness. There was limited evidence that incidents, feedback and audits were used to make improvements. However, the provider was responsive to some of the feedback from our inspection and made some improvements following immediate feedback, such as ensuring oxygen was stored securely and revising their information governance policy. They later made other improvements, such as revising policies and ensuring staff attended fire drills.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Following the inspection, we took immediate enforcement action as a result of our findings. We issued a Warning Notice, on the 26 May 2021, under Section 29 of the Health and Social Care Act 2008. We required the provider to make significant and immediate improvements in the quality of healthcare it provides.

Regulated activity	Regulation
Surgical procedures	Regulation 17 CQC (Registration) Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983 Following the inspection, we took immediate enforcement action as a result of our findings. We issued a Warning Notice, on the 26 May 2021, under Section 29 of the Health and Social Care Act 2008. We required the provider to make significant and immediate improvements in the quality of healthcare it provides.