EF Medispa Kensington

Quality Report

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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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Summary of findings

Letter from the Chief Inspector of Hospitals

EF Medispa is operated by The Beautiful Body Company.

The service provides cosmetic surgery and other cosmetic treatments to people over the age of 18 years old. The service does not have inpatient beds and all patients are seen as day cases. Facilities include one minor operations/surgical procedure room and one pre assessment room. The service also has a recovery area and two consultation rooms.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 11 January 2018.

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.

Services we do not rate

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- The service was visibly clean.
- All staff we spoke with were aware of the importance of the duty of candour.
- Consent practices were clearly outlined and always followed.
- Patients spoke very highly of the nursing staff and spoke positively about the service as a whole.
- The service had been adapted to meet the needs of patients. The elective procedures were planned with the patients' needs in mind.
- Staff spoke very highly of their senior management team.

However, we also found the following issues that the service provider needs to improve:

- There were no formal pain assessment tools used by the clinic.
- There was no formal assessment of patient outcomes.
- There was no evidence that the service encouraged patients to seek counselling services if required.
- There was no formal inclusion or exclusion policy.

Amanda Stanford

Deputy Chief Inspector of Hospitals (London)

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		Surgery was the only activity carried out in the service. Whilst we regulate cosmetic surgery services we not have a legal duty to rate them. Overall, surgical services at the service did keep patients and staff safe from avoidable harm. Surgical services were as effective as they could be and the service had plans to submit data to national bodies. Patients were more than satisfied with care and treatment received and spoke very highly of the staff, especially the nurses. Treatment was highly individualised but there was no clear inclusion or exclusion policy. Leaders were visible and staff felt as though senior management were very supportive.

Summary of findings

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Location name here

Services we looked at: Surgery

Summary of this inspection

Background to EF Medispa Kensington

EF Medispa is operated by The Beautiful Body Company. The service opened in 2008. It is a private clinic in Kensington, London. All patients are privately funded.

The service offers a range of cosmetic treatments, with three procedures falling under our regulation. These are: breast enhancement, fat transfer and Vaser liposuction. Breast enhancement surgeries are not performed at the service and instead are performed by a self-employed consultant at another site. The other two procedures are performed on site.

The registered manager for the service is Esther Fieldgrass, who has been the registered manager and the nominated individual since 2008.

The hospital also offers cosmetic procedures such as ultraformer, intense pulsed light (IPL) skin rejuvenation, laser hair removal and skin facials and peels. We do not regulate these procedures.

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 Michelle Gibney, Inspection Manager.

Information about EF Medispa Kensington

The service provides day surgery and is registered to provide the following regulated activities:

- Surgical procedures
- Treatment of disease, disorder or injury

During the inspection, we visited the whole service. We spoke with six staff including registered nurses and reception staff. We also received eight 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 10 sets of patient records.

There were no special reviews or investigations of the clinic ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice since 2013, with the most recent inspection taking place in February 2014. Both inspections found that the service was meeting all standards of quality and safety it was inspected against.

Activity (December 2016 – November 2017):

- In the reporting December 2016 to November 2017, there were 129 day case episodes of care recorded at the service; all of these were privately funded.
- Out of these 129 procedures, 112 were liposuction and 17 were fat transfers.

Two surgeons and a bank of anaesthetists worked at the clinic but only one of these surgeons performed surgeries under the regulated activities. Two registered nurses and a team of receptionists were also employed full time by the service.

Track record on safety

Between December 2016 and November 2017 there were:

- No never events.
- No serious incidents.
- One surgical site infection (SSI).
- 17 complaints, only five of which related to the regulated activity.

Summary of this inspection

Services provided at the hospital under service level agreement:

- Pathology services
- Sterilisation services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- The service was clean throughout.
- All staff we spoke with were aware of the importance of the duty of candour.
- All electrical equipment had been tested and was within date with all upcoming inspection dates logged.
- The service complied with the AFPP guidelines on safe staffing.

However, we also found the following issues that the service provider needs to improve:

- There was no formal inclusion or exclusion policy.
- The records were not always fully completed by both doctors and anaesthetists in the first instance.

Are services effective?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- Consent practices were clearly outlined and always followed.

However, we also found the following issues that the service provider needs to improve:

- There were no formal pain assessment tools used by the clinic.
- There was no formal assessment of patient outcomes.

Are services caring?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- Patients spoke very highly of the nursing staff and spoke positively about the service as a whole.

However, we also found the following issues that the service provider needs to improve:

- There was no evidence that the service encouraged patients to seek counselling services if required.

Summary of this inspection

Are services responsive?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- The service had been adapted to meet the needs of its patients. The elective procedures were planned with the patients' needs in mind.

Are services well-led?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- Staff spoke very highly of their senior management team.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

The main service provided by EF Medispa was cosmetic surgery.

Incidents

- Between November 2016 and December 2017 there was one clinical incident. This involved a patient developing an infection post-procedure which was adequately followed up.
- There had been no never events at the service between November 2016 and December 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death, but neither need have happened for an incident to be a never event.
- In the same reporting period, there had been no serious incidents. A serious incident requires investigation and can be identified as an incident where one or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened.
- Staff we spoke with understood how to report incidents and were aware of the duty of candour (DoC). 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. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. There were no incidents during the reporting period that met the threshold for DoC.
- Senior staff were able to explain the process behind an incident occurring. Staff recalled a needle-stick injury that took place at the service before the reporting period. Staff clearly outlined the process and procedures that took place as a result and the learning that was shared at the service.
- In the event of an incident, a paper log and online log were kept. The incidents would then be discussed at the quarterly management meetings.
- The service undertook minor surgical procedures that were all carried out under local anaesthetic and conscious sedation. No procedures were carried out under general anaesthetic.

Clinical Quality Dashboard

- The service did not have a quality dashboard but did monitor key quality outcomes e.g. returns to theatres, patients transferred out. For example, during the reporting period there were no unplanned returns to theatre post-operatively, nor were there any patients transferred to alternative care following treatment.

Cleanliness, infection control and hygiene

- The theatre, medication room, sluice room and recovery area were all visibly clean and well organised. We observed an infection control risk assessment that assessed the whole service for cleanliness. All staff were trained in infection control.
- All patients having a surgical procedure had a MRSA swab test and full blood count, haematology,

biochemistry and clotting screen. We observed evidence of this in the notes. The service did not screen patients for Clostridium Difficile (C.Diff) or methicillin sensitive staphylococcus aureus (MSSA).

- We observed posters in the theatre and sluice room displaying instructions for the correct hand washing technique and what to do in the event of a needle-stick injury. The service completed hand hygiene audits every month. Between September and December 2017 theatre staff achieved 100% compliance with good hand hygiene practice. We did not observe hand sanitising gel located throughout the service but there were hand washing basins in the sluice and consulting rooms. The recovery area was adjacent to the bathroom, which also contained a wash basin.
- There were adequate supplies of personal protective equipment (PPE), for example, gloves, aprons and shoe covers in the theatre area.
- In theatres, there was a cleaning log that contained step-by-step instructions on what needed to be cleaned and when. Staff signed this log on a daily basis. We viewed this log whilst on inspection and found it to be fully completed and up to date.
- There was a service-level agreement with an NHS trust for the provision of decontamination services. Staff informed us that this worked well.
- The infection control risk assessment looked at cleanliness of all the equipment in the treatment room and theatre. All surfaces and areas were free of dust and clean.

Environment and equipment

- The reception, waiting area and consulting room were located on the ground floor of the building to the service. The surgical procedure room and recovery area were located in the basement level with no step-free access. This meant that patients had to walk upstairs following conscious sedation. This was not on the service risk register.
- There was a small waiting area with tea and coffee making facilities, as well as a water dispenser.
- There was one minor operations/surgical procedure room. This room was used for surgical procedures under local anaesthetic and conscious sedation. Resuscitation equipment in the theatre was stored securely in a designated trolley. We checked the trolley and found all equipment to be in date. Audits kept with the trolley displayed that staff had checked it on a weekly basis. All single-use items were in date. The recovery area consisted of one bed in the room next to the surgical procedure room. One patient could be accommodated at any given time.
- All portable equipment we checked had been recently serviced and labelled to indicate the next review date. Disposable equipment was easily available, in date and appropriately stored. In the theatre, all equipment was safety tested regularly and was all in date.
- We observed a record of the electrical safety testing of equipment dating back two years. The defibrillator, BP monitor and emergency oxygen had all been safety tested in the year prior to inspection. All the dates were logged in an audit book. The medical gas was also safety tested every month.
- The arrangements for the management of waste products and clinical specimens were appropriate for keeping patients and staff safe from harm. Sharps bins were used correctly and sluice areas included bins that were adequately labelled and classified to ensure segregation of waste.

Medicines

- Whilst the service stored basic medicines such as painkillers, all controlled drugs (CDs) were brought on site by the anaesthetist. There was no risk assessment carried out for this and the provider did not take oversight for the CDs the anaesthetist brought in. All other medicines were stored in a locked cupboard. Staff understood and demonstrated how to report medicine safety incidents. Learning from these incidents was then fed back through various channels.
- We observed the medicines management audit from August 2017 to January 2018 and noted that in 100% of cases staff were recording and storing medicines correctly.
- There was one fridge that often stored drugs and nothing else. The fridge temperature was within range and the log was fully completed and up to date. The fridge was locked and only accessible by a key held by the nurse in charge.

- All the medicines we checked were in date.
- All patient allergies were clearly documented in the prescribing documents used.

Records

- Patient records were paper based. The records were kept in a secure office at the service.. The pre-operative assessment included a list of risks, full medical history and terms and conditions.
- The records audits that we reviewed stated that the anaesthetist and doctors records were often left incomplete. An audit of 23 records in September 2017 showed that 56% of records were fully completed by doctors. An audit of 15 records in November 2017 stated that in 40% of records the anaesthetist records were not fully updated. The service re-audits all audits in order to assure accuracy and found 100% compliance in all areas. Also, our audit of ten patient records showed that records were comprehensive, legible and up to date.
- Information governance formed part of the mandatory training programme, which all staff were required to attend. 100% of staff were trained in information governance.

Safeguarding

- All staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. Staff in the clinic understood safeguarding procedures and how to report concerns. Safeguarding policies were up to date and readily available in the service.
- All staff were trained in adult safeguarding at level two. This was updated on an annual basis. The medical department manager was the safeguarding lead and was trained to level three.
- Staff were aware of whom the safeguarding lead was and the escalation process if they had any concerns.
- There had been no reported safeguarding incidents to the CQC in the 12 months prior to the inspection.

Mandatory training

- Staff received mandatory training on a rolling annual programme that consisted of both e-learning and classroom courses. The mandatory training programme included: health and safety, information governance, fire safety, equality and diversity, infection control, food hygiene, basic life support (BLS), moving and handling, safeguarding vulnerable children, protection of vulnerable adults, complaints handling and conflict management. All nursing staff were 100% up-to-date with mandatory training.

Assessing and responding to patient risk

- Initial consultations were done face-to-face with both the surgeon and the patient present at any time that suited the patient.
- Although there was no formalised inclusion or exclusion policy, senior staff informed us that they did not treat any patients with a high body mass index (BMI) or mental health issues. The final decision on whether or not to operate would lie with the anaesthetist who would make a decision based on the blood test results. The service did not treat any patients under 18 years old, nor did they treat patients requiring wheelchair access.
- It is a requirement of the Royal College of Surgeons (RCS) that the consultation phase identifies any patients who are psychologically vulnerable and that those patients are appropriately referred for assessment. The pre-procedure consultation took place in line with RCS guidelines and ensured that all patients who were psychologically fit for a procedure were not provided with one. This was confirmed by the each of the ten medical records we looked at.
- There were processes in place to reduce the risks to patients undergoing surgery. These included the service adopting the use of the World Health Organisation (WHO) surgical safety checklist. This checklist was developed to reduce errors and adverse events, and increase teamwork and communication in surgery. The service also had a policy for patient identification and pre-operative checks. This policy stated that the medical practitioner was responsible for confirming patient details prior to the procedure. We observed evidence of this in all the records we checked.
- Patients were provided with a two week “cooling off” period after initial consultation. This provided them with the opportunity to think about their decision to have surgery based on all the risks.

Surgery

- Both nurses had up-to-date basic life support (BLS) training.
- There were clear guidelines and policies for the management of suspected sepsis based on NICE guidelines. There were also posters in the theatre on how to manage sepsis so that staff were fully aware. All clinical staff were trained in sepsis management and were aware of the steps to take in the event of suspected sepsis.
- The service was not open 24 hours a day so could not provide a 24-hour hotline. The service did however provide all patients with a number to call during business hours if they had any questions or queries. There was an effective system in place for post-operative patients to contact the consultant and senior members of the service directly outside of normal working hours.
- The nursing staff also followed up with all patients post procedure.

Nursing and support staffing

- Due to the size of the service, staff were allocated in advance based on demand. The Royal College of Nursing (RCN) recommends a nurse to patient ratio of 1:8 (RCN 2012). This means one registered nurse (RN) for eight patients. At the time of our inspection, the service maintained a ratio of one registered nurse to one patient.
- There was one whole time equivalent full-time nurse and one part-time nurse employed by the service at the time of the inspection.
- We observed the service policy on staffing and found that it contained a policy for induction of new staff. This document outlined all the skills and competencies that were required of surgical nurses.
- The Association of Perioperative Practitioners (AFPP) Safe Staffing guidelines were used to determine safe staffing levels in the perioperative environment. The AFPP guidelines recommend a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list. The rotas we observed confirmed that the service followed this guidance.
- Between November 2016 and December 2017, four shifts were occupied by either bank or agency nurses. Senior staff informed us that due to the specialist nature of the service, they prepared to plan their nursing schedule in advance to avoid and limit the use of agency or bank nurses.
- There were no vacancies at the time of our inspection.
- There were also receptionist staff at the service.

Surgical staffing

- Surgeons worked under a practising privileges agreement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The service had two surgeons working under a practising privileges arrangement but only one of these surgeons performed surgeries under the regulated activity.
- An anaesthetist was present in all procedures where conscious sedation was required and stayed with their patients post-operatively. This was in line with the Royal College of Surgeons (RCS) and Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines.

Emergency awareness and training

- The provider had a detailed fire risk management policy in place that outlined guidance on what to do if a fire took place at the service. The service had adequate provision for evacuation in the event of a fire.
- The mandatory training programme included fire training, in which 100% of staff were trained.
- All fire extinguishers we observed were in date and had been safety tested.
- The service did not have a back-up emergency generator in case of failure of essential services. But the service did have a back-up power supply which runs for 30 minutes at a time.

Are surgery services effective?

Evidence-based care and treatment

Surgery

- Service policies were available in a folder at the service. Most of the surgical policies and procedures we reviewed referenced relevant NICE and Royal College guidelines. All policies were in date and had a named author.
- Both pre-operatively and post-operatively the service complied with the evidence based guidelines provided by the National Institute for Health and Care Excellence (NICE).
- The service maintained a clinical audit plan. There were several quarterly audits, including: consent, clinical governance and infection prevention and control. The feedback from these audits would go in the staff room and would be shared with nurses directly.
- Although there was no policy for patients requiring psychiatric assessment the patients informed us that the staff did assess the patients well-being at consultation.

Pain relief

- There was no adequate ways for staff to know a patients pain levels. There were no formal pain assessment tools used by the clinic. This meant that staff could not be fully assured of the level of pain a patient was in.
- Upon discharge, all patients were provided with the number for the service and guidance on pain relief. They were advised to call in if they experienced unmanageable pain.
- The service closely monitored discharged patients and contacted all patients post procedure.
- Patients were prescribed pain killers to take home with them post procedure. If the patient finished their medication and was still in pain, they could call the service and meet with the doctor to see what further medication needed to be prescribed.

Nutrition and hydration

- Staff followed the Association of Anaesthetist of Great Britain and Ireland (AAGBI) best practice guidance on fasting prior to surgery. We observed the service policy on this and saw evidence in the records.
- The service only had one recovery area and all patients were day case episodes, therefore there were no food facilities for patients. Drinking water was available in the waiting area.
- The service informed us that if the patient had surgery under local anaesthetic, there was very small risk of nausea and vomiting. If the patient did suffer from nausea, then the medical practitioners would administer fluids and anti-nausea medications. If patients had been sedated, the anaesthetist would manage postoperative nausea and vomiting with medication and remain with the patient until they were satisfied the patient could be discharged.

Patient outcomes

- The service was small and therefore did not contribute to any national databases. However, the service did have plans to start providing data to commence submitting data to Quality Patient Reported Outcome Measures (QPROMS) in the coming year. QPROMS are recommended by the Royal College of Surgeons and involve the patient completing a pre and post-operative satisfaction survey based on the outcome of the cosmetic surgery. QPROMS are recommended for the breast augmentation surgery which, whilst arranged by the service, did not take place on site.
- The service tended to measure outcomes on a visual basis, by taking 'before' and 'after' photos of all their patients. This also enabled the patient to see the visual changes post procedure.
- The service did not submit data to the Private Healthcare Information Network (PHIN). Independent services are expected to submit data to PHIN if they are carrying out cosmetic procedures such as liposuction.
- Between November 2016 and December 2017, there were 129 procedures carried out on site. There were no unplanned returns to theatre post-operatively during that period, nor were there any patients transferred to alternative care following treatment.
- The provider did not participate in the Anaesthesia Clinical Services Accreditation scheme (ACSA).

Competent staff

Surgery

- The service only accepted surgeons that had a responsible officer and means of receiving an appraisal each year. Both medical and nursing staff had been appraised in the past year.
- We observed the personnel files for both nurses and doctors and found them to be complete and concise.
- Nursing staff informed us that the service was very responsive to their continued development.

Multidisciplinary working

- Whilst on inspection, we observed varied professionals working together to plan the delivery of patient care. There was positive communication between both doctors and nurses
- There was a service level agreement (SLA) with an NHS trust for the provision of decontamination services. Staff informed us that this worked well. There was also an SLA with a pathologist unit to carry out bloods and other tests.

Seven-day services

- The service was open Monday to Sunday. On Monday and Friday the service operated between 9am and 7pm. From Tuesday to Thursday the service operated from 9am to 8pm. On the weekends the service operated from 10 to 6pm. Theatre lists tended to run on Wednesdays and Fridays.

Access to information

- All surgical patients were pre-assessed and had to take part in blood tests prior to the procedure. After the assessment, the notes were provided to the anaesthetist and consultant.
- The blood were tested by an external laboratory. The results could be back at the service anywhere between a few hours and a day. The service informed us that this worked very well. The results would then be signed off by the consultant and anaesthetist.
- The patients GP was only contacted with the consent of the patient if the surgeon deemed it necessary e.g. to discuss a present medical condition that the patient might have. Discharge was not communicated to GP's.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Although the provider's consent policy did not reference the Royal College of Surgeons Professional Standards for cosmetic surgery with regards to consent we observed that the process for seeking consent was adequately monitored and each patient's consent was taken at several stages prior to each procedure.
- These standards state that consent must be obtained in a two-stage process with a cooling-off period of at least two weeks between the stages to allow the patient to reflect on the decision.
- The services consent policy followed the Department of Health's protocol on good practice in consent (HSC 2001/023). This protocol outlines that informed consent involves time for the patient to "reflect and think about the decision".
- We observed ten patient records and found that they all contained signed consent forms and evidence that the patient's received a cooling off period. The audit of the patient records confirmed that 100% of patient records during the three month period prior to inspection had adequate consent forms.
- Senior staff spoke us through the 'cooling-off period' and informed us that any patient who changed their mind during this time would be fully reimbursed.
- The service only accepted low-risk, medically fit patients with full capacity. The senior staff informed us that these factors formed part of their decision making process as to whether to take a patient on. Despite this, staff were fully aware of the Mental Capacity Act 2005 and Do Not Attempt Cardio Pulmonary resuscitation (DNACPR) orders.

Are surgery services caring?

Compassionate care

- There were no procedures on the day of our inspection, therefore we did not speak with any patients.
- We sent 'Tell us about your care' comment cards to the provider before the inspection and asked for them to be made available to patients. We received eight 'Tell us about your care' comment cards completed by patients.

All eight were overwhelmingly positive about the service. One patient stated that the service was "first class" whilst another stated that the treatment received was "excellent".

Understanding and involvement of patients and those close to them

- Patients were advised about the cost and the expectations of their treatment at the initial consultation with a treatment coordinator. At this consultation, the patient would be given an estimate with the final cost being confirmed by the surgeon. Once the patient had met the surgeon the treatment coordinator would put together the final quote. In accordance with the service policy, the surgery could not be booked for at least two weeks after the surgeon meeting the patient so that the patient had time to consider the surgery and cost.
- Staff encouraged patients to bring a friend or family member along to the service for their consultations both with the surgeon and the treatment coordinator.

Emotional support

- Whilst the service did not provide any counselling services, comments we received from patients stated that the nursing staff were very supportive. One patient stated that whilst she had a fear of needles the nursing staff were "brilliant both in surgery and with aftercare". Another patient stated that the nursing staff always make her feel "calm and at ease".

Are surgery services responsive?

Service planning and delivery to meet the needs of local people

- The service was open seven days a week and provided elective surgery by appointment only. Appointments were made via the phone or online. Theatre lists tended to run on Wednesdays and Fridays. This meant that admissions were planned with the patient in mind. Senior staff informed us that their theatre was often underutilised and there was more demand for non-invasive procedures.
- All procedures were carried out on patients over 18 years old.

Access and flow

- The service contact details could be accessed via their website online. Patients could receive more information about procedures over the phone before they arrived at their initial consultation.
- Initial consultations were done face-to-face with both the surgeon and the patient present at any time that suited the patient. The patient then had a two week 'cooling-off period' which gave them time to reconsider the procedure. The usual waiting time between the end of the 'cooling-off period' and the procedure was four weeks. After this time the patient had blood tests and any other necessary pre-checks to ensure they fell within the service's informal inclusion criteria.
- On the day of the procedure, the patient was provided with pre-operative information and all expectations were discussed with the surgeon.
- Post procedure, the patient would recover in the recovery room. The patient was provided with discharge information and the number of the service if they had any issues. The service would call patients within 24 hours post-operatively.
- In the 12 months prior to inspection, no procedures were cancelled by the service. In the same reporting period there was one return to theatre.

Meeting people's individual needs

- The service did not treat patients with learning difficulties or dementia as part of their informal exclusion policy.
- The service was unable to offer both access and toilet facilities for patients requiring wheelchair access.
- The service did not admit a large number of overseas patients, so translation services were not available in house. The hospital did however have access to interpretation service via telephone.

Learning from complaints and concerns

- All complaints were dealt with on an informal basis in the first instance. The medical department manager had overall oversight of the complaints received.

Surgery

- The provider policy for receiving and acting on complaints stated that all complaints must receive written acknowledgement within two working days with a full response being made to the complainant within 20 working days.
- Between December 2016 and November 2017, there were 17 complaints received by the service. Only five of these complaints related to the regulated activity.
- The complaints related to a number of concerns including, service related issues such as booking an appointment, refunds and payments, aesthetic outcomes and injectable treatments. We observed evidence that all complaints were actioned immediately and within the set timeframe. None of these complaints were escalated to the Independent Sector Complaints Adjudication Service (ISCAS).

Are surgery services well-led?

Leadership / culture of service related to this core service

- The service was led by the registered manager who was also the CQC responsible individual. The senior leadership team consisted of the registered manager, the company director and the medical department manager.
- All staff we spoke with reported that they enjoyed working at the service as it had a "family feel". Staff felt supported to develop and found management "inspiring" and "supportive".
- To ensure that their marketing was honest and responsible the service did not utilise any promotional tactics that might encourage people to make ill-advised decisions. We observed that the service's marketing was created in accordance with advertising guidelines and codes of conduct.
- The service website stated "Results and benefits can vary and are different for each individual. As such, EF MEDISPA cannot guarantee specific results". We observed that the marketing and advertising techniques used by the service were in accordance with the Committee on Advertising Practice's (CAP).

Vision and strategy for this core service

- The vision of the service was to continue to provide high quality care. This vision was written in the staff handbook. Staff of all levels knew the vision of the service and understood its importance for the service brand. There was no specific documented strategy for the implementation of this vision.

Governance, risk management and quality measurement

- The service had a formal governance structure in place with a medical advisory committee (MAC). We observed the minutes from one of the meetings that the MAC held and found them to be thorough.
- There was no formal review of surgical outcomes, but the service would take 'before' and 'after' photos for the benefit of the patient so that they could see how much they had changed. This system worked well for the service.
- Complaints were handled informally, in the first instance, and then discussed at the weekly managers meetings. These complaints were then audited and the results also discussed. We observed the results of these audits and found that they adequately discussed ways for the service to improve but the majority of complaints related to patients "not being happy with results". Senior management informed us that they ensure that patients' expectations are managed appropriately to ensure they aren't unhappy post procedure. The auditing of complaints took place every quarter.
- Whilst the service did not have a risk management policy, it did maintain a live risk assessment form that actively kept track of all the current risks at the service. At the time of our inspection the risk assessment log maintained only non-clinical risks. The service did however possess clinical risks, for example, patients walking up the stairs post sedation. The service did not have any tools to mitigate this risk.

Public and staff engagement

- Staff informed us that there were senior management were very approachable and always around for support.
- The senior executive team informed us that the 'open door' policy and the small nature of the service meant that there was no need for formal engagement. This was verified by staff who stated that there was frequent and effective communication with the executive team.

Surgery

- The Friends and family test (FFT) is a quick and anonymous way for patients to give their views after receiving care or treatment across the NHS. Being a small, private clinic, the service did not carry out an FFT. The provider informed us that patients were encouraged to give feedback and we observed several comment boxes around the service. The service did not formally collate this information.

Innovation, improvement and sustainability

- The service had plans to continue to carry out more non-surgical procedures.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The service should ensure that there is a policy for patients requiring psychiatric assessment.
- The service should ensure that the consent policy makes reference to the Royal College of Surgeons Professional Standards for cosmetic surgery.
- The service should ensure that all records are fully completed bydoctors and anaesthetists.
- The service should ensure that there are formal pain assessment tools used.
- The service should ensure that there are formal assessments of patient outcomes.
- The service should revise its risk assessment policy to include all potential risks to patients, for example, a patient walking up stairs following conscious sedation.
- The service should consider formalising and minuting governance meetings.
- The service should ensure that they risk assess the controlled drugs brought into the service.
- The service should ensure it submits data to the appropriate networks.