# Re-Enhance Limited

## 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

## Overall summary

Re-Enhance is operated by Re-Enhance Limited. The service offer cosmetic day case services for surgery (liposuction procedures), dental treatments and medicine services (bio-identical hormone therapies) for adults. Facilities include four treatment rooms and diagnostic facilities. The service provides surgery, medicine and dental services.

Following our inspection on 1 and 14 March 2017 we issued warning notices against the registered manager and nominated individual. The warning notices were issued as a result of regulatory breaches relating to safe care and treatment, good governance, fit and proper persons employed and staffing.

We carried out this unannounced focussed inspection to see if the clinic had met the concerns we raised in the warning notice following our inspection in March 2017.

At the previous inspection on 1 and 14 March 2017 we found the following issues that the service provider needed to improve:

- Staff did not have current statutory training in key areas such as health and safety, manual handling, fire safety and infection control. Staff also did not have current safeguarding training.
- The system to learn from and make improvements following any accidents, incidents or significant events required improvement.
- The clinic did not have any standard operating procedures for bio-identical hormones and did not reference applicable guidance.
- Whilst patients' needs were assessed and their care was planned and delivered in line with the clinical lead's range of course guidance materials, patients' records did not demonstrate how the clinic complied with these standards and how decisions were made.
- At the time of our inspection, audits were not undertaken to monitor compliance with guidance and standards.
- At the time of our inspection, outcomes of people's care and treatment were not routinely collected and monitored.
- Patient records were not completed in line with the GMC guidance on good record keeping. They lacked evidence of comprehensive pre-assessment and clinical reasoning for decision-making was not contained within patients' medical records.
- There was no documented process for referring patients on to services such as counselling, if needed.
- The provider did not have a clear governance framework and management could not evidence that they regularly reviewed the systems that were in place.
- There was not a comprehensive assurance system and service performance measures in place at the time of our inspection.

# Summary of findings

- The provider did not have arrangements in place to collate information to monitor and manage quality and performance.
- Not all staff that were registered with the General Dental Council (GDC) could provide evidence that met the requirements of their professional registration by carrying out regular training and continuing professional development (CPD).

We inspected this service on 30 May 2017 to check whether improvements had been made. At this inspection we found that the clinic had met the requirements of the warning notice because:

- Managers had a clear oversight of the issues we had previously identified and had put in place systems and processes to address them.
- Immediate patient safety issues had been addressed. Medicines and other consumable items were stored and handled appropriately. There were systems in to monitor and audit infection prevention and control processes.
- Patient records had been revised and included relevant information such as risk assessments, medical histories and details of prescribed medication.
- Equipment used for patient treatment, including emergency equipment, was available and checked on a routine basis.
- Recruitment processes were clearly defined. Staff had completed their mandatory training and annual appraisals. Staff competencies were assessed and reviewed.
- Senior staff had developed an evidence-based governance structure. Risk assessments for staff had been developed. A risk register was in place to enable leaders within the clinic to have an oversight of key risks to the service.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

# Summary of findings

## Contents

# Summary of this inspection

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and a specialist advisor with expertise in medicine. The inspection team was overseen by Lorraine Bolam, Acting Head of Hospital Inspection.

# 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?

Following our inspection on 1 and 14 March 2017 we issued warning notices against the registered manager and nominated individual. At the time of the first inspection we identified the following areas that the provider needed to improve:

- Patient records lacked evidence of comprehensive pre-assessment and clinical reasoning for decision-making was not contained within patients' medical records.
- Staff did not have training in areas such as safeguarding, health and safety, manual handling, fire safety and infection control.
- The system to learn from and make improvements following any accidents, incidents or significant events required improvement.
- The service was not undertaking six-monthly infection control assessments in line with the government Health Technical Memorandum (HTM 01-05). Legionella risk assessments had not been carried out.
- Dental and medical consumables and medication in the surgery had passed their expiry date.
- The clinical lead did not have current advanced life support (ALS) training and staff were not trained on the use of the resuscitation equipment.
- Trainee dental nurses were not familiar with recommended manual decontamination protocols.
- A risk management process had not been undertaken for the safe use of sharps (needles and sharp instruments.
- Records of Hepatitis B immunisation were not available and risk assessments had not been carried out on staff who were involved with exposure prone procedures but could not demonstrate immunity.
- The practice recruitment policy was not in line with requirements.

We inspected this service on 30 May 2017 to check whether improvements had been made. We found the requirements of the warning notice were met because:

- Systems and processes had been introduced to address patient safety concerns we had identified.
- Processes were in place to ensure there was comprehensive assessment of patients prior to, during and after procedures.
- Equipment used for patient treatment, including emergency equipment, was available and checked on a routine basis.

# Summary of this inspection

## Are services effective?

Following our inspection on 1 and 14 March 2017 we issued warning notices against the registered manager and nominated individual. At the time of the first inspection we identified the following areas that the provider needed to improve:

- The clinic did not have any standard operating procedures for bio-identical hormone therapies and did not reference applicable guidance.
- Staff within the service and the registered manager confirmed that staff members did not have appraisals.
- The registered manager and clinical lead were not able to provide any written evidence of the monitoring of staff competency to undertake key aspects of their roles such as taking bloods and provision of intra-muscular injections.

We inspected this service on 30 May 2017 to check whether improvements had been made. We found the requirements of the warning notice were met because:

- The provider had developed evidence-based standard operating procedures that were based on a range of national and international best practice guidelines.
- Staff files evidenced that all staff had received basic life support training. The clinical lead and a senior nurse had completed advanced life support training.
- Staff had all had annual appraisals and had a plan in place to address their professional development needs. Staff competencies were assessed and reviewed.

## Are services caring?

## Are services responsive?

## Are services well-led?

Following our inspection on 1 and 14 March 2017 we issued warning notices against the registered manager and nominated individual. At the time of the first inspection we identified the following areas that the provider needed to improve:

- At the time of our inspection senior leaders within the clinic did not demonstrate a comprehensive awareness of the information they needed to manage the clinic.
- The provider did not have effective systems and processes in place to ensure there was appropriate governance and managerial oversight of the clinic.
- The provider did not have a clear governance framework and management could not evidence that they regularly reviewed the systems that were in place.

# Summary of this inspection

- There was not a comprehensive assurance system and service performance measures in place at the time of our inspection.
- The provider did not have arrangements in place to collate information to monitor and manage quality and performance.

We re-inspected this service on 30 May 2017. The requirements of the warning notice were met because:

- An additional staff member with governance experience had been recruited.
- The provider had developed governance and quality monitoring procedures to give managers documented oversight of the issues within the clinic.
- Senior staff had developed an evidence-based governance structure. Risk assessments for staff had been developed.
- A risk register was in place to enable leaders within the clinic to have an oversight of key risks to the service.

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care | N/A | N/A | N/A | N/A | N/A | N/A |
| Surgery | N/A | N/A | N/A | N/A | N/A | N/A |

# Medical care

| | |
|---|---|
| Safe | |
| Effective | |
| Well-led | |

## Are medical care services safe?

Safe means the services protect you from abuse and avoidable harm.

### Incidents

- The clinic had introduced a comprehensive health and safety policy which outlined the incident reporting procedure. We saw evidence that incidents had been reported and that learning following incidents had started to be shared at team meetings.

### Cleanliness, infection control and hygiene

- The registered manager and clinical lead had arranged for a legionella assessment to be undertaken and this had been completed at the time of our inspection.
- In accordance with the government Health Technical Memorandum (HTM 01-05) reviews of infection control and prevention standards had been scheduled so they were to be carried out on a six monthly basis.

### Environment and equipment

- The registered manager and clinical lead had introduced a stock rotation system, which was audited, to ensure stock and consumables that had past their expiry date were removed and appropriately discarded of. All the medicines and consumable items we saw were within their expiry dates and stored appropriately.
- The emergency resuscitation equipment trolley contents matched those recommended in the quality standards for cardiopulmonary resuscitation practice and training set out by the resuscitation council UK (2015). We saw evidence that the trolley was regularly checked.

### Medicines

- The provider had introduced medication management procedures and a policy addressing this area. Medication was kept in locked cupboards or clinical rooms. We saw evidence of a collection procedure for medication and the clinic staff were clear on their recall procedure.
- The storage cupboards did not contain any staff members' medications, as they had done previously. Topical medications were appropriately stored in accordance with the manufacturers' guidelines.

### Records

- Patients' records were securely stored at the time of our inspection. We reviewed six patients' records, which were complete, dated and signed.
- Further treatment was prescribed with clear records of the decision making process being recorded in patients' treatment records. Prescribed treatment was recorded including medications administered, batch numbers/ date of expiry for injectables.

### Safeguarding

- The clinical lead had level three adults safeguarding training. All other staff had level two adults safeguarding. This was in line with the intercollegiate guidance and best practice.

### Mandatory training

- We reviewed all staff training files and saw evidence that staff had undertaken fire safety, manual handling and infection control training. The clinic had a comprehensive list of what the provider considered mandatory, which included key areas including moving and handling, infection control and the use of display screen equipment.
- Staff files evidenced that staff received control of substances hazardous to health (COSHH) training, basic risk assessment training and stipulated when updates in essential areas including safeguarding training were due.

### Assessing and responding to patient risk

- The clinical lead had revised documentation to ensure that patients' records were contemporaneous and

contained a risk assessment based on the procedure the service user was undergoing. Medical histories of people using the service were comprehensive and contained a detailed questionnaire, which took into account key issues such as other long term or chronic health conditions. There was evidence in records that the doctor had reviewed the questionnaire and discussed it with people using the service.

## Are medical care services effective?

Effective means that your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.

**Evidence-based care and treatment**

- The clinical lead had developed standard operating procedures for the medical procedures undertaken. These were in accordance with a range of clinical guidance material and included a defined admission policy. The policy included the criteria patients must meet to be considered for treatment and clear exceptions. The admission policy requirements were reflected in the pre-assessment questionnaire that the clinical lead had developed.

**Competent staff**

- Staff files evidenced that all staff had received basic life support training. The clinical lead and a senior nurse had completed advanced life support training.
- All staff files had competency assessments completed within them. The clinical lead had set up an assessment schedule for him to review staff competencies periodically.
- Staff had all had annual appraisals and had a plan in place to address their professional development needs.
- There was evidence of a clear recruitment policy and referencing process.

## Are medical care services well-led?

Well-led means that the leadership, management and governance of the organisation make sure it provides high-quality care based on your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

**Governance, risk management and quality measurement**

- The clinic had introduced record keeping audits, monitoring of patient outcomes audits and were in the process of collating evidence of improvement to the quality and safety of the services provided. The clinical lead and registered manager had introduced systems and processes to help them have documented oversight of the clinic.
- Risk assessments for staff had been developed which included a risk assessment for the risk for staff being exposed to hepatitis b if they were not immune.
- The service had developed a risk register to enable leaders within the clinic to have an oversight of risk.
- We reviewed the clinic's policies and procedures. They reflected the latest guidance and legislation applicable. There was version control or review dates.Surgery

# Surgery

| | |
|---|---|
| Safe | |
| Effective | |

## Are surgery services safe?

Safe means the services protect you from abuse and avoidable harm.

**Records**

- Patients' records were securely stored at the time of our inspection. We reviewed three patients' records, which were complete, dated and signed.

**Assessing and responding to patient risk (theatres, ward care and post-operative care)**

- The professional standards for cosmetic surgery state that the doctor performing a cosmetic surgery procedure should assess the patient's suitability for the procedure, taking into account their medical history, general health, age, co-morbidities, ongoing medications or other planned procedures. We reviewed three patients' records and saw evidence of comprehensive assessments.
- The clinical lead had developed a surgical safety checklist, in accordance with the World Health Organisation surgical safety checklist, to ensure appropriate checks prior to, during and following surgery. The clinic planned to audit these checklists to ensure learning opportunities were not missed. Are surgery services effective?

## Are surgery services effective?

Effective means that your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.

**Evidence-based care and treatment**

- The clinical lead was developing his understanding of the latest guidance from Royal College of Surgeons dated April 2016 relating to the requirements of the cosmetic specialist registrar and assessing the impact on the clinic. He was liaising with colleagues regarding best practice guidance regarding volumes of liposuction removal and in the process of collating an evidence base to support his practice.
- The clinical lead had developed a defined admission policy including the criteria patients must meet to be considered for treatment with clear exceptions. The admission policy was reflected in the pre-assessment questionnaire that had been developed.

**Patient outcomes**

- The clinical lead and registered manager had developed their understanding of the private health information network (PHIN) and were looking at which patient outcomes should be reported.